

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8692 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08672

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>A.A. Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>Mayo</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. Anne Arundel Gen.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Calvin Alexander</u>	4. DATE OF DEATH Month <u>Aug</u> Day <u>30</u> Year <u>1960</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-23-1918</u>
9. AGE (In years last birthday) <u>42</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>	
11. KIND OF BUSINESS OR INDUSTRY <u>Washington D.C. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Nannie Barnes</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-16-8268</u>	
17. INFORMANT <u>Virginia Alexander Mayo Md.</u>		Address <u>...</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>...</u> DUE TO (c) <u>...</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>...</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Chen</u>		DATE SIGNED <u>8/3/60</u>	
EXAMINER'S NAME (Type) <u>E. Linhart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-4-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Marks</u>	22d. LOCATION (City, town, or county) (State) <u>Mayo, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr. - Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 1 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur A. ...</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, with the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

08673

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FILE NO.  
DEPT.

11.11.1914  
11.11.1914

DATE

11.11.1914

TIME

AGE

SEX

11.11.1914

TIME

11.11.1914  
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## CERTIFICATE OF DEATH

Reg. Dist. No.

08673

8693

1. PLACE OF DEATH a. COUNTY <b>Maryland</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>50 yrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>USNH, Annapolis, Md.</b>				d. STREET ADDRESS <b>711 Melrose St.</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Elizabeth</b> Last <b>ALLSTON</b>				4. DATE OF DEATH Month <b>August</b> Day <b>14th</b> Year <b>60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-27-09</b>	
9. AGE (In years lost birthday) <b>50</b> yrs.		IF UNDER 1 YEAR Months <b>50</b> Days <b>14</b> Hours <b>19</b> Min.		IF UNDER 24 HRS. Months <b>50</b> Days <b>14</b> Hours <b>19</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Louis FISHER</b>				14. MOTHER'S MAIDEN NAME <b>Mary E. PARKINSON</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Husband 711 Melrose St., Annapolis, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>---</b> DUE TO (c) <b>---</b> INTERVAL BETWEEN ONSET AND DEATH <b>20 minutes</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>---</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8-14-60</b> , 19 <b>---</b> , to <b>8-14-60</b> , 19 <b>---</b> , that I last saw the deceased alive on <b>8-14-60</b> , 19 <b>---</b> , and that death occurred at <b>8:20P M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>---</b> DATE SIGNED <b>8-15-60</b>							
ACTUAL SIGNATURE <b>William F. Branch</b>				PHYSICIAN'S NAME (Type) <b>Frank William KRONE, Jr.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug 18-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Memorial</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Saylor Sons</b>				24a. REC'D BY REGISTRAR <b>AUG 17 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8737

## CERTIFICATE OF DEATH

Reg. Dist. No.

08674

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u> c. LENGTH OF STAY IN 1b <u>2 wks.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1625 Pleasantville Dr.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena (Green Gables)</u> d. STREET ADDRESS <u>Box # 4 Rt. 1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM G. ARAND</u>		4. DATE OF DEATH Month Day Year <u>August 12 1960</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4th Aug. 1883</u>		9. AGE (In years lost birthday) yrs. <u>77</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter (ret)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self Emp.</u>				11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Unknown (Arand)</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>217-09-0283</u>				17. INFORMANT Address <u>Mrs. Maud Wever, 1625 Pleasantville Dr. Glen Burnie, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia bronchial terminal</u> DUE TO <u>177X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Carcinoma of prostate with wide spread metastasis</u> DUE TO (c) <u>spread metastasis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>177X</u>																INTERVAL BETWEEN ONSET AND DEATH			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Aug 1, 1960</u> to <u>Aug 12 1960</u> that I last saw the deceased alive on <u>Aug 12, 1960</u> and that death occurred at <u>3:45 AM</u> from the causes and on the date stated above.																			
ACTUAL SIGNATURE <u>Morton M. Guiger</u>				ADDRESS (Street, city or town, state) <u>5210A Ritchie Hwy. - 25</u>				DATE SIGNED <u>8/15/60</u>											
PHYSICIAN'S NAME (Type)																			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>16 Aug. 60</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Maryland</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard V. Singleton</u>				ADDRESS <u>Glen Burnie, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 17 '60</u>				24b. REGISTRAR'S SIGNATURE <u>Richard V. Singleton</u>							



TO FUNERAL DIRECTOR: A copy of this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RECORDS AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08675

8738

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>H.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MARGARETS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ST. MARGARETS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>BELFIELD FARM</u>		d. STREET ADDRESS <u>BELFIELD FARM</u>	
3. NAME OF DECEASED (Type or print) <u>MATHILDE G BARCHET</u>		4. DATE OF DEATH <u>August 29 1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-22-1873</u>
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>CARL FRIEDRICH GROSSE</u>		14. MOTHER'S MAIDEN NAME <u>MATHILDE P. BARCHET</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>MRS. W.W. WARLICK</u>		Address <u>131 Charles St. Annapolis, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO (b) <u>Arteriosclerotic C. V. Disease</u> DUE TO (c) <u>422.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>August 15, 1960</u> to <u>Aug. 29, 1960</u> , that (I) (we) last saw the deceased alive on <u>Aug. 15, 1960</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Maurice F. Klawans</u>		22b. DATE SIGNED <u>8/29/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>MAURICE F. KLAWANS</u>		22d. ADDRESS <u>31 SOUTH GATE AVE.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>8-31-60</u>	<u>FAMILY CEMT.</u>	<u>ST. MARGARETS, MD.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. G. Sons Annapolis, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>SEP 1 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Krawns</u>			

(M)

X

MEDICAL CERTIFICATION

08875



CERTIFICATE OF DEATH

1918

Number of Death 211

Age 21 years

Sex Male

Color of Skin White

Height 5 feet 10 inches

Weight 150 pounds

Build Medium

Complexion Fair

Hair Brown

Eyes Blue

Mouth Well formed

Nostrils Well formed

Ears Well formed

Throat Well formed

Neck Well formed

Shoulders Well formed

Arms Well formed

Hands Well formed

Feet Well formed

Legs Well formed

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8739

Items 11 12 Film G270 9-6-60 et

CERTIFICATE OF DEATH

Reg. Dis. 08676

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE _____ b. COUNTY _____	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laurel, Md.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington, D.C.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street or institution) <u>District Training School</u>		d. STREET ADDRESS <u>434 - 1st Street S.W.</u>	
3. NAME OF DECEASED (Type or print) First <u>Leon</u> Middle <u>E.</u> Last <u>Barnes</u>		4. DATE OF DEATH Month <u>August</u> Day <u>25</u> Year <u>1960</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 15, 1918</u>
9. AGE (In years last birthday) yrs. <u>42</u>		10. IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>institutionalized</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	
11. BIRTHPLACE (State or foreign country) <u>District of Columbia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>unknown</u>		14. MOTHER'S MAIDEN NAME <u>Evelyn Parker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>--</u>	
INFORMANT <u>Children's Center, Laurel, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <u>Massive hemoptysis due to acute congestive failure secondary to severe pulmonary hypertension</u> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>745X</u> DUE TO <u>Severe kyphoscoliosis of thoracolumbar spine</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Advanced chronic lung disease</u> (c) <u>Advanced chronic lung disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>2 days</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>--</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>--</u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>--</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Aug. 23, 1960</u> , to <u>Aug. 25, 1960</u> , that I last saw the deceased alive on <u>Aug. 24, 1960</u> , and that death occurred at <u>3:13 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Children's Center, Laurel, Md.</u> DATE SIGNED <u>8/26/60</u>			
ACTUAL SIGNATURE <u>George T. Economos</u>		M.D. <u>Children's Center, Laurel, Md.</u>	
PHYSICIAN'S NAME (Type) <u>George T. Economos, M.D.</u>		<u>Children's Center, Laurel, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-26-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>District Training School</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John R. Willetts DTS Laurel Md</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 30 '60</u>	
ADDRESS <u>Children's Center, Laurel, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoms</u>	



08076

CENTRAL OF DEPT

8132

1

Handwritten notes at the bottom of the page, including the name "J. B. Smith" and other illegible text.

## CERTIFICATE OF DEATH

Reg. Dist. No.

08677

8740

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MILLERSVILLE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ODENTON</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>KNOLLINGWOOD NURSING HOME</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>BEACH</u> Last		4. DATE OF DEATH Month <u>AUGUST</u> Day <u>21</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>? ? , 1860</u>
9. AGE (In years last birthday) <u>100</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>Canada</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Unknown</u>	
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY NO. <u>none</u>		INFORMANT Address <u>Mrs. OLIVE W. King, Friend, Gambrills, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Centriocerebral cardiovascular disease</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO			INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>dry gangrene of right foot</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>June</u> , 19 <u>60</u> , to <u>August 21</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>August 21</u> , 19 <u>60</u> , and that death occurred at <u>7:30</u> M., from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>John Hedeman</u> M.D.		ADDRESS (Street, city or town, state) <u>121 Cathedral</u> DATE SIGNED <u>8/22/60</u>	
PHYSICIAN'S NAME (Type) <u>JOHN HEDEMAN M.D.</u>		<u>Annapolis Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug. 23, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR DATE <u>AUG 24 '60</u>		24b. REGISTRAR'S SIGNATURE <u>William S. Kraus</u>	

1

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

1987

CERTIFICATE OF DEATH

85-11



*[Faint, mostly illegible text from a form, likely containing personal and medical details.]*

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8694 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 8 Film G269 8-26-60 et

Reg. Dist. No. 08678

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>3801-4</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b <u>1 Day</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 17-42</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. Anne Arundel General</u>				d. STREET ADDRESS <u>923 N. Calhoun St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Walter</u> Middle <u>Bibbins</u> Last <u>Bibbins</u>				4. DATE OF DEATH Month <u>8</u> Day <u>20</u> Year <u>1960</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/10/1991</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months <u>5</u> Days <u>10</u>		IF UNDER 24 HRS. Hours <u>10</u> Min. <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BOAT CAPTAIN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SHIPPING</u>		11. BIRTHPLACE (State or foreign country) <u>Accomac Co. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ISAIAH BIBBINS</u>				14. MOTHER'S MAIDEN NAME <u>MAGGIE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>411-11-1111</u>		17. INFORMANT <u>William Bibbins 2129 W. North Ave</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Disease</u> 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/25/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>West Calvary</u>		22d. LOCATION (City, town, or county) _____ (State) _____ <u>A.A. Co. MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Mrs. S. P. Hayes 638 N. 9th St</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 23 '60</u>		24b. REGISTRAR'S SIGNATURE <u>S. Hayes</u>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08679

8741

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Near Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Near Annapolis</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>RIVA Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Donald</u> Middle <u>M.</u> Last <u>Brattain</u>		4. DATE OF DEATH Month <u>August</u> Day <u>13</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 20, 1920</u>
9. AGE (In years last birthday) <u>40</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Travel Agent</u>		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Paul H. Brattain</u>	
14. MOTHER'S MAIDEN NAME <u>Nellie Morris</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give post or dates of service) <u>Yes</u> <u>WW II</u>	
16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Paul H. Brattain</u> Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> 823X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Apparently lost control of the car on wet pavement, skidded off the road and hit a tree.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>4:27</u> a.m. <u>PM</u> <u>8/13</u> 19 <u>60</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Riva Rd. Rte 450</u>	20f. (City or town) <u>nr. Annapolis</u> (County) <u>AA</u> (State) <u>Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. Linhardt</u>		DATE SIGNED <u>8-13-60</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Aug 17-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Memorial</u>	22d. LOCATION (City, town, or county) <u>Annapolis</u> (State) <u>Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		24a. REC'D BY REGISTRAR <u>  </u>	24b. REGISTRAR'S SIGNATURE <u>  </u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Pages 1 and 2 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 20 - Newspaper

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# 1 8695 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

Reg. Dist. No.

08680

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			
c. LENGTH OF STAY IN 1b <b>10 yrs.</b>							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>62 College Creek Terrace</b>				d. STREET ADDRESS <b>62 College Creek Terrace</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Charles Henry</b> Middle <b>Brown</b> Last				4. DATE OF DEATH Month <b>August</b> 10 Day <b>10</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 30-1885</b>		9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>General Utilities</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>		11. BIRTHPLACE (State or foreign country) <b>Anne Arundel Co. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Robert Brown</b>				14. MOTHER'S MAIDEN NAME <b>Sorena Ford</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> If yes, give war or dates of service		16. SOCIAL SECURITY NO. <b>219-16-0625</b>		17. INFORMANT <b>Edna S. Brown - 62 College Crk. Terrance</b> Address <b>Annapolis,</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> <b>420.1</b> DUE TO <b>Arteriosclerotic Cardiovascular Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>?</b> DUE TO (c) <b>?</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 10, 1960</b> , to <b>August 10, 1960</b> , that I last saw the deceased alive on <b>August 10, 1960</b> , and that death occurred at <b>12:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Clay Street Annapolis, Maryland</b> DATE SIGNED <b>Aug 16 '60</b>							
ACTUAL SIGNATURE <b>R. L. Richardson</b> M.D.							
PHYSICIAN'S NAME (Type) <b>R. L. Richardson</b>				Clay Street Annapolis, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 13-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Brewer Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>C. E. Hicks 111 Annapolis, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 16 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: Also this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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8696  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
08681

1. PLACE OF DEATH a. COUNTY <i>A. A.</i> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A. A.</i>	
c. LENGTH OF STAY IN 1b <i>10</i>		d. STREET ADDRESS <i>28 Shaw Street</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>Elizabeth</i> First <i>Brown</i> Middle <i>Brown</i> Last		4. DATE OF DEATH Month <i>8</i> Day <i>2</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>7-6-1906</i>
9. AGE (In years last birthday) <i>54</i> yrs.		10. IF UNDER 1 YEAR: Months <i>54</i> Days <i>34</i> Hours <i>10</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Alexander Abrams</i>		14. MOTHER'S MAIDEN NAME <i>Elsie Hopkins</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>(If yes, give war or dates of service)</i>		16. SOCIAL SECURITY NO. <i>Joseph Brown</i>	
17. INFORMANT <i>28 Shaw St.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gremia</i> DUE TO <i>260X</i> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (c) <i>Nephritis</i> <i>Diabetes Mellitus (Insure)</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 wk</i> <i>1 yr.</i> <i>2 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerosis &amp; Hypertensive Cardiovascular Dis</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>9/26</i> 1956 to <i>8-2</i> 1960 that (I) (we) lost the deceased alive on <i>Aug 2</i> 1960 and that death occurred at <i>M</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Thye W. Gilman</i> M.D.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <i>62 Cathedral St. Annapolis</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>8-5-1960</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hills</i>		23d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>William Reesett Anna. Md</i>		25a. REC'D BY REGISTRAR <i>Aug 4 '60</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles E. K...</i>			



08081

DEPARTMENT OF DEATH

8008



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8697 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08682

1. PLACE OF DEATH a. COUNTY <u>A.A. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) ✓ a. STATE <u>MD.</u> b. COUNTY <u>—</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				c. LENGTH OF STAY IN 1b <u>—</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. Anne Arundel Gen.</u>				e. STREET ADDRESS <u>2511 N. Calvert</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>J</u> Last <u>Brownlee</u>				4. DATE OF DEATH Month <u>8</u> Day <u>14</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 2, 1908</u>	9. AGE (In years last birthday) <u>52</u> yrs.	IF UNDER 1 YEAR Months <u>—</u> Days <u>—</u>	IF UNDER 24 HRS. Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tool &amp; Die Maker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Weiskettle Co</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore County, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Brownlee</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Curran</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-01-5890</u>		17. INFORMANT Address <u>Mrs. Mary F. Brownlee, 2511 N. Calvert Street</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac disease</u> <u>4-34-4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Sudden</u> DUE TO (c) <u>—</u>							INTERNAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour <u>—</u> a. m. <u>—</u> p. m. <u>—</u> 19 <u>—</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. Linhart</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8/14/60</u>			
EXAMINER'S NAME (Type) <u>E. Linhart</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL CREMATION, (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>8-18-60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>A.A. County, Mc</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street</u>			24a. REC'D BY REGISTRAR DATE <u>AUG 17 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

08738

MASSACHUSETTS MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH		RACE		RELIGION		MARRIAGE		EDUCATION		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH		DATE OF DEATH		TIME OF DEATH		SIGNATURE OF EXAMINER		OFFICE OF EXAMINER		COUNTY		STATE		FEDERAL DISTRICT		POST OFFICE		ZIP CODE	
John J. Baker		Male		45		1900		Boston		Massachusetts		United States		White		Roman Catholic		Married		High School		Carpenter		Heart Disease		Natural		Home		1950		10:00 AM		John J. Baker		Boston		Massachusetts		District of Columbia		Washington, D.C.		20001			
John J. Baker		Male		45		1900		Boston		Massachusetts		United States		White		Roman Catholic		Married		High School		Carpenter		Heart Disease		Natural		Home		1950		10:00 AM		John J. Baker		Boston		Massachusetts		District of Columbia		Washington, D.C.		20001			

## CERTIFICATE OF DEATH

Reg. Dist. No.

08683

8698

1. PLACE OF DEATH a. COUNTY <u>A.A. Annapolis</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>a.a.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. Gen. Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Eulie</u> Middle <u>Buckmaster</u> Last <u>Buckmaster</u>				4. DATE OF DEATH Month <u>8</u> Day <u>14</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-16-92?</u> <u>68?</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <u>Lebanon, Conn.</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John B. Buckmaster</u>				14. MOTHER'S MAIDEN NAME <u>Ann Butler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>200-03-4425</u>		17. INFORMANT <u>Bertrude M. Buckmaster</u>		Address <u>Arnold St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery insufficiency</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>5 yrs.</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>60</u> , to <u>August</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>March 20</u> , 19 <u>60</u> , and that death occurred at <u>2:45</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>121 Cathedral St. Annapolis, Md.</u> DATE SIGNED <u>8/14/60</u>							
ACTUAL SIGNATURE <u>John B. Buckmaster</u> M.D.				PHYSICIAN'S NAME (Type) <u>Annapolis, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-17-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Balto Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Balto City Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Louison</u>				ADDRESS <u>2357 Wash Blvd Balto 80nd</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 17 '60</u>	
24b. REGISTRAR'S SIGNATURE							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

8699

08684

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>10 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>L</b> Last <b>BULL</b>				4. DATE OF DEATH Month <b>August</b> Day <b>30</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 11, 1895</b>	
9. AGE (In years last birthday) yrs. <b>65</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Sales-lady</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail Clothing</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>				13. FATHER'S NAME <b>Oliver S. League</b>			
14. MOTHER'S MAIDEN NAME <b>Ida Fouche</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no no</b>			
16. SOCIAL SECURITY NO. <b>213-24-336</b>				17. INFORMANT <b>Mrs. Rosella B. Stinchcomb- Daughter- Mayo, Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary edema</b> DUE TO (b) <b>Heart failure</b> DUE TO (c) <b>Coronary heart disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic</b> <b>Chronic</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 hr.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (or <del>we</del> ) attended the deceased from <b>Aug. 20, 1960</b> to <b>Aug. 30, 1960</b> , that (I) (or <del>we</del> ) last saw the deceased alive on <b>Aug. 30, 1960</b> and that death occurred at <b>10:30 P.M.</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Stuart M. Christhilf</b>				22b. DATE <b>8/31/60</b>			
22c. PHYSICIAN'S NAME (Type) <b>Stuart M. Christhilf</b>				22d. ADDRESS <b>69 Franklin St., Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 3, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mayo Memorial Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Mayo, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>				25a. REC'D BY REGISTRAR <b>SEP 6 '60</b>			
ADDRESS <b>Annapolis, Md.</b>				25b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>			

242

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• Diffusion - the random movement of particles from an area of high concentration to an area of low concentration.

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. This certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8742

## CERTIFICATE OF DEATH

Reg. Dis. 08685

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel County</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Washington</b> b. COUNTY <b>D.C.</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel, Maryland</b>		c. LENGTH OF STAY IN 1b <b>9 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Children's Center Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Laurel, Maryland</b>	
3. NAME OF DECEASED (Type or print) First <b>Tyrohe</b> Middle <b>Ellsworth</b> Last <b>Butler</b>		4. DATE OF DEATH Month <b>8</b> Day <b>12</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-21-44</b>
9. AGE (In years last birthday) <b>16</b> yrs.		10. IF UNDER 1 YEAR Months <b>16</b> Days <b>12</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Inmate</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Institution</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ellsworth Gibbons</b>		14. MOTHER'S MAIDEN NAME <b>Inez Butler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Informant</b> <b>Children's Center Records</b> Address <b>Laurel, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Severe nutritional anemia</b> <b>002X</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>Pulmonary congestion with terminal weeks pneumonia.</b> (c) <b>Possibility of Pulmonary T.b.c. to be considered</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Several weeks</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>Cerebral Cortical Atrophy secondary to birth injury.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8-11-1960</b> to <b>8-12-1960</b> , that I last saw the deceased alive on <b>8-12-1960</b> , and that death occurred at <b>8:30 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Geo T Economos</b>		ADDRESS (Street, city or town, state) <b>Children's Center Hospital</b>	
PHYSICIAN'S NAME (Type) <b>George T. Economos, M.D.</b>		DATE SIGNED <b>Laurel, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/16/60</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Children's Center Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Laurel Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hoones Jr. D.T.S. Laurel Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 18 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>			

1938

CONFIDENTIAL

8545



8743

## CERTIFICATE OF DEATH

Reg. Dist. No.

08686

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Kent</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. LENGTH OF STAY IN 1b <b>5 months 21 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Henry</b> Last <b>Butler</b>				4. DATE OF DEATH Month <b>8</b> Day <b>30</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 9, 1903</b>	
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR: Months <b>8</b> Days <b>30</b> Hours <b>19</b> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Unknown</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Maxwell Butler</b>				14. MOTHER'S MAIDEN NAME <b>Cora ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Dehydration &amp; Emaciation</b> <b>322.2</b> DUE TO <b>Chronic Brain Syndrome Associated with Alcoholic Intoxication</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>-----</b> DUE TO (c) <b>-----</b>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> <del>Not at work</del> <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>	
20f. (City or town) <b>-----</b> (County) <b>-----</b> (State) <b>-----</b>							
21. I certify that I attended the deceased from <b>3/9</b> , 19 <b>60</b> to <b>8/30</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>8/30</b> , 19 <b>60</b> , and that death occurred at <b>7:34 A.</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>8/30/60</b>							
ACTUAL SIGNATURE <b>L. Benedict, M. D.</b>				PHYSICIAN'S NAME (Type) <b>Crownsville State Hospital, Md.</b> <b>8/30/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/1/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Still Pond, Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Still Pond, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bennett W. W. W.</b> ADDRESS <b>Chestertown, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>SEP 2 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Henshaw</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. This certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Page 3 should be detached for use as the burial-transit permit.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08688

1. PLACE OF DEATH a. COUNTY <i>A. A. County</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A. A.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b <i>10</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>44 Pleasant St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Clarence</i> First <i>Clarence</i> Middle <i>Car</i> Last <i>Car</i>		4. DATE OF DEATH Month <i>8</i> Day <i>31</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-4-1893</i>
9. AGE (In years last birthday) <i>67</i> yrs.		10. IF UNDER 1 YEAR Months <i>6</i> Days <i>7</i> Hours <i>15</i> Min.	11. IF UNDER 24 HRS. Months <i>6</i> Days <i>7</i> Hours <i>15</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Electrician Helper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Maryland</i>	
11. BIRTHPLACE (State or foreign country) <i>U.S.A.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Carr</i>		14. MOTHER'S MAIDEN NAME <i>Lurema Carr</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Yes</i>		16. SOCIAL SECURITY NO. <i>212-14-9170A</i>	
17. INFORMANT <i>W. W. T.</i> Address <i>212-14-9170A</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Esophagus &amp; Stomach</i> DUE TO (b) <i>150X</i> DUE TO (c) <i>1 year</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>8/11</i> to <i>8/31</i> , 19 <i>60</i> , that (I) <del>the</del> last saw the deceased alive on <i>8/30</i> , 19 <i>60</i> , and that death occurred on <i>8/31</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>W. W. T.</i>		22b. DATE SIGNED <i>9/1/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>W. W. T.</i>		22d. ADDRESS <i>110-6645 ST ANNAPOLIS</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>9-6-1960</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>National</i>		23d. LOCATION (City, town, or county) (State) <i>Annapolis Md.</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>William Ruesett</i>		25a. REC'D BY REGISTRAR DATE <i>SEP 1 '60</i>	
25b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>			







## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

08689

Reg. Dist. No.

8702

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>12 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Wesley</u> Last <u>Chambers</u>				4. DATE OF DEATH Month <u>August</u> Day <u>7</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 16-1879</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Huckster</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Anne Arundel Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Wesley</u>				14. MOTHER'S MAIDEN NAME <u>Nancy Lane</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>John T. Chambers - 1 Hick Ave. Annapolis, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchitis</u> DUE TO (c) <u>Dilated Atherosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>15 yrs</u> <u>15 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>7/26</u> , 19 <u>60</u> , to <u>8/7</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8/7/60</u> , 19 <u>  </u> , and that death occurred at <u>3:30 P.</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Herbert H. Johnson</u> M.D.							
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 10-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>C.E. Hick 111</u>				ADDRESS <u>Annapolis, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 16 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hunt</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: All of this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



05080

5032



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8744

## CERTIFICATE OF DEATH

Reg. Dist. No.

08690

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>McKendree</u>		c. LENGTH OF STAY IN 1b <u>6 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1</u>		d. STREET ADDRESS <u>McKendree</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DAVID WALTER CHESSE</u>		4. DATE OF DEATH Month Day Year <u>AUGUST 31 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/21/02</u>
9. AGE (In years last birthday) <u>58</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Foreman, F.E.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STATISTICIAN</u>	
11. BIRTHPLACE (State or foreign country) <u>Pittsberry Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>La Yelle</u>	
13. FATHER'S NAME <u>WALTER CHESSE</u> <u>DAVID WALTER</u>		14. MOTHER'S MAIDEN NAME <u>MARY STONE Boles</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>040-20-1184</u>	
17. INFORMANT <u>Mrs. C. T. Joy</u>		Address <u>7451 Avenida Alhambra, Calif.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>viral pneumonia</u> DUE TO <u>492X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>acute myocardial failure</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, lactory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-19, 1960</u> to <u>8-20, 1960</u> , that I last saw the deceased alive on <u>8-19, 1960</u> , and that death occurred at <u>8 A. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Emily H. Molen</u>		DATE SIGNED <u>8-22-60</u>	
PHYSICIAN'S NAME (Type) <u>Emilio H. Molen</u>		M.D. <u>Lothman, M.D.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/27/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Christ Church</u>		22d. LOCATION (City, town, or county) (State) <u>YORKTOWN Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u>		24a. REC'D BY REGISTRAR <u>AUG 25 '60</u>	
ADDRESS <u>Harley St. 1122</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>	

CERTIFICATE OF DEATH

87-6

08300

NAME OF DECEASED		DATE OF BIRTH		SEX		RACE		MARITAL STATUS		OCCUPATION	
JAMES H. HARRIS		JAN 15 1895		M		W		MARRIED		FARMER	
PLACE OF BIRTH		DATE OF DEATH		TIME OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
BALTIMORE, MD.		JAN 20 1945		10:30 AM		HEART DISEASE		NATURAL		HOME	
AGE AT DEATH		DATE OF INTERMENT		TIME OF INTERMENT		PLACE OF INTERMENT		NAME OF MINISTER		NAME OF FUNERAL HOME	
50 YEARS		JAN 22 1945		10:00 AM		BALTIMORE, MD.		REV. J. H. HARRIS		J. H. HARRIS	
EDUCATION		SCHOOLING		REMARKS		SIGNATURE OF PHYSICIAN		SIGNATURE OF MINISTER		SIGNATURE OF FUNERAL HOME	
HIGH SCHOOL		HIGH SCHOOL		DECEASED WAS FOUND BY NEARBY NEIGHBOR		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
PREVIOUS ILLNESS		PREVIOUS ILLNESS		PREVIOUS ILLNESS		PREVIOUS ILLNESS		PREVIOUS ILLNESS		PREVIOUS ILLNESS	
NONE		NONE		NONE		NONE		NONE		NONE	
DATE OF EXAMINATION		DATE OF EXAMINATION		DATE OF EXAMINATION		DATE OF EXAMINATION		DATE OF EXAMINATION		DATE OF EXAMINATION	
JAN 20 1945		JAN 20 1945		JAN 20 1945		JAN 20 1945		JAN 20 1945		JAN 20 1945	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
DATE OF EXAMINATION		DATE OF EXAMINATION		DATE OF EXAMINATION		DATE OF EXAMINATION		DATE OF EXAMINATION		DATE OF EXAMINATION	
JAN 20 1945		JAN 20 1945		JAN 20 1945		JAN 20 1945		JAN 20 1945		JAN 20 1945	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH AND IS NOT VALID FOR ANY OTHER PURPOSE.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

8703

08691

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN lb <b>24 minutes</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
f. STREET ADDRESS <b>8811 Glenville Road</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Einar</b> Last <b>CHRISTENSEN</b>		4. DATE OF DEATH Month <b>August</b> Day <b>9</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 1, 1918</b>
9. AGE (In years lost birthday) <b>42</b> yrs.		10. IF UNDER 1 YEAR Months <b>42</b> Days <b>0</b> Hours <b>0</b> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Owner</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Gas Stations</b>	
13. BIRTHPLACE (State or foreign country) <b>WASHINGTON, D.C.</b>		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. FATHER'S NAME <b>EINAR CHRISTENSEN</b>		16. MOTHER'S MAIDEN NAME <b>MABEL FENDER</b>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		18. SOCIAL SECURITY NO. <b>577-01-8673</b>	
19. INFORMANT <b>Mrs. Coote L. Christensen, 8811 Glenville Rd.</b>		Address <b>Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> DUE TO <b>4200</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>coronary arterio sclerosis</b> DUE TO <b>? years.</b> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 9, 1960</b> , to <b>Aug. 9, 1960</b> , that (I) <del>had</del> last saw the deceased alive on <b>Aug. 9, 1960</b> , and that death occurred at <b>4:25 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>G. Church</b>		22b. DATE SIGNED <b>8/10/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Gerald Church</b>		22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>8/22/60</b>	23c. NAME OF CEMETERY OR CREMATORY <b>GEO. WASH. CEMETERY</b>	23d. LOCATION (City, town, or county) (State) <b>PRINCE GEO. COUNTY, MARYLAND</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond A. Ziska</b>		25a. REC'D BY REGISTRAR <b>AUG 15 60</b>	
ADDRESS <b>SILVER SPRING, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur A. Howard</b>	

10381

CERTIFICATE OF DEATH

8103



NAME OF DECEASED: [Illegible]  
AGE: [Illegible]  
SEX: [Illegible]  
DATE OF BIRTH: [Illegible]  
DATE OF DEATH: [Illegible]  
PLACE OF DEATH: [Illegible]  
CAUSE OF DEATH: [Illegible]  
MANNER OF DEATH: [Illegible]  
SIGNATURE OF PHYSICIAN: [Illegible]  
SIGNATURE OF WITNESS: [Illegible]  
OFFICIAL USE: [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: A copy of this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove copies of pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

8704

08692

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>Mulberry Hill</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Mary</b>		First <b>Mary</b> Middle <b>COATES</b> Last <b>COATES</b>		4. DATE OF DEATH <b>August 4 1960</b>		Month <b>August</b> Day <b>4</b> Year <b>1960</b>	
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 11, 1882</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min. <b>77</b>		IF UNDER 24 HRS. Months <b>77</b> Days <b>77</b> Hours <b>77</b> Min. <b>77</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Dora Owens</b>				14. MOTHER'S MAIDEN NAME <b>Eliza Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> If yes, give war or dates of service				16. SOCIAL SECURITY NO. <b>7</b>		17. INFORMANT <b>Della Cook Annapolis Md</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute Pulmonary Edema</b> 434.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>acute Congestive Cardiac Failure</b> DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 3, 1960</b> , to <b>Aug. 3, 1960</b> , that (I) <del>was</del> last saw the deceased alive on <b>Aug. 4, 1960</b> , and that death occurred at <b>5:35 A.M.</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Ardis T. Allen</b>				22b. ADDRESS <b>61 Chestnut St</b>		22c. DATE SIGNED <b>8/4/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>ARDIS T. ALLEN</b>				22d. ADDRESS <b>61 Chestnut St</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/8/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt Auburn</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Elroy S. Wilson 1000 Brantley Ave</b>				25a. REC'D BY REGISTRAR <b>AUG 8 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

08098

CERTIFICATE OF DEATH

8700

INVESTIGATION AND DEPARTMENT OF HEALTH  
CITY OF NEW YORK

NAME: *John J. [illegible]*  
AGE: *45*  
SEX: *Male*  
RACE: *White*  
BIRTH: *October 12, 1882*  
PLACE OF BIRTH: *New York City*  
OCCUPATION: *Police Officer*  
CAUSE OF DEATH: *Heart Disease*  
DATE OF DEATH: *October 15, 1927*  
PLACE OF DEATH: *New York City*  
SIGNATURE: *[illegible]*  
TESTIFY: *[illegible]*

*John J. [illegible]*  
*Police Officer*  
*New York City*  
*October 15, 1927*



may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

8705

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08693

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>E.</u> Last <u>Coates</u>				4. DATE OF DEATH Month <u>August</u> Day <u>18</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-12-1872</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Maryland</u>		11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>Joseph Coates</u>				14. MOTHER'S MAIDEN NAME <u>Fannie Coates</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes</u> <u>Spanish American</u>				16. SOCIAL SECURITY NO. <u>177X</u>			
17. INFORMANT <u>Mary E. Coates</u>				Address <u>58 Pleasant St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>metastases</u> DUE TO (c) <u>CA Prostate</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH <u>1 mo</u> <u>6 mo</u> <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4/57</u> 19 <u>57</u> to <u>8/18</u> 19 <u>60</u> that (I) (we) last saw the deceased alive on <u>8/18/60</u> 19 <u>60</u> , and that death occurred at <u>1:50</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Edwin Davis</u>				22b. DATE SIGNED <u>1960</u>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8-23-60</u>		<u>National</u>		<u>Annapolis Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>William Reesett</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 24 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Charles L. Haines</u>	

850

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
8745  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08694

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>A.F.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>South River</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>South River Edgewater</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A. A. Co. Home</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Henrietta</i> Middle <i>Rogers</i> Last <i>Craig</i>		4. DATE OF DEATH Month <i>8-</i> Day <i>3</i> Year <i>1960</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 5 1874</i>
9. AGE (In years last birthday) <i>85</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Chesapeake Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>James W. Rogers</i>		14. MOTHER'S MAIDEN NAME <i>Mary E. Phipps</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>604-14-1234</i>	
17. INFORMANT <i>George Craig</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>General Carcinomatosis</i> DUE TO <i>Carcinoma, st. breast</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>2 yrs.</i> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arteriosclerotic Cardio Vascular Disease</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>1958</i> to <i>Aug 3, 1960</i> that (I) (we) last saw the deceased alive on <i>Aug 1, 1960</i> and that death occurred at <i>6 PM</i> , from the causes and on the date stated above.			
22a. SIGNATURE <i>Maurice F. Krawans</i> M.D.		22b. DATE SIGNED <i>8/4/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>MAURICE F. KRAWANS, MD</i>		22d. ADDRESS <i>31 Southgate W. Annapolis Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Aug 5 1960</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Bluff Cmt</i>		23d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Saylor Son</i>		25a. REC'D BY REGISTRAR DATE <i>AUG 8 '60</i>	
25b. REGISTRAR'S SIGNATURE <i>William L. Travis</i>			



**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

8706

08695

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>164 Williams Drive</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Lillie</b> Middle <b>M.</b> Last <b>CURRAN</b>				4. DATE OF DEATH Month <b>August</b> Day <b>31</b> Year <b>19 60</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 10, 1888</b>		9. AGE (In years last birthday) <b>72</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John R. Fouché</b>				14. MOTHER'S MAIDEN NAME <b>Annie R. Medford</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <b>John R. Taylor</b>		Address <b>(2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF COLON</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <b>3 WKS</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>HYPERTENSIVE HEART DISEASE; DIABETES MELITUS</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) <del>attended</del> attended the deceased from <b>Aug. 17, 1960</b> to <b>Aug. 30, 1960</b> , that (I) <del>had</del> last saw the deceased alive on <b>Aug. 30, 1960</b> , and that death occurred at <b>1:10 A.M.</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Edward S. Beck</b>				22b. DATE SIGNED <b>8/31/60</b>		22c. PHYSICIAN'S NAME (Type) <b>Edward S. Beck</b>	
22d. ADDRESS <b>71 Franklin St., Annapolis, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept 2-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Bluff Cent</b>		23d. LOCATION (City, town, or county) (State) <b>Annapolis Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor Sons</b>				25a. REC'D BY REGISTRAR DATE <b>SEP 2 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08880

2508

CERTIFICATE OF DEATH

Name of deceased		Age		Sex		Race		Date of birth		Place of birth	
John Doe		45		Male		White		Jan 10, 1925		New York, N.Y.	
Cause of death		Disease		Organ		Nature		Time		Place	
Heart failure		Myocardial infarction		Heart		Natural		Jan 15, 1970		New York, N.Y.	
Signature of physician		Signature of registrar		Signature of informant		Signature of witness		Signature of funeral director		Signature of undertaker	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of death		Time of death		Place of death		Cause of death		Disease		Organ	
Jan 15, 1970		10:30 AM		New York, N.Y.		Heart failure		Myocardial infarction		Heart	
Issued by		Date of issue		Place of issue		Cause of death		Disease		Organ	
John Doe		Jan 15, 1970		New York, N.Y.		Heart failure		Myocardial infarction		Heart	

1

Veritas



1

## CERTIFICATE OF DEATH

8707

08696

Items 13, 14 Film 2-0 9 6 50

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>70 yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Galesville</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>7</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Frank</b>		First Middle Last <b>DAVIS</b>		4. DATE OF DEATH Month Day Year <b>August 16 1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 17, 1883</b>		9. AGE (In years last birthday) <b>77</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>ENGINEER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>ICE PLANT</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>N</b>		16. SOCIAL SECURITY NO. <b>213050064</b>		17. INFORMANT <b>14 yrs Della Davis Galesville Md</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary failure</b> <b>163X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CA lung (metastases)</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b> <b>2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>physician</b> attended the deceased from <b>Feb. 20, 1960</b> to <b>Aug. 16, 1960</b> , that (I) <b>did</b> last saw the deceased alive on <b>Aug. 16, 1960</b> , and that death occurred at <b>6:15 P.M.</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Edwin Davis, Jr.</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8/23/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edwin Davis, Jr.</b>				22d. ADDRESS <b>98 Cathedral St., Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Buried</b>		23b. DATE THEREOF <b>8/19/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>our Lady of Sorrows</b>		23d. LOCATION (City, town, or county) (State) <b>owensville Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Bureau Burdette</b>				ADDRESS <b>Galesville Md</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 26 1960</b>	
				25b. REGISTRAR'S SIGNATURE <b>Carroll S. French</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: A copy of this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8746

## CERTIFICATE OF DEATH

08697

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel County</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>A. A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Magothy, Maryland</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box 511 Pasadena, Md.</u>				d. STREET ADDRESS <u>/ Box 511 Pasadena, Md.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>James Henry Edwards</u> Middle Last				4. DATE OF DEATH Month <u>August 27,</u> Day Year <u>19 60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 18, 1898</u>		9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Pasadena, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Willie Edwards</u>				14. MOTHER'S MAIDEN NAME <u>Annie Edwards</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		INFORMANT Address <u>Delia E. Edwards Box 511 Pasadena, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate</u> 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 19 55</u> to <u>August 25, 19 60</u> that I last saw the deceased alive on <u>August 25, 19 60</u> , and that death occurred on <u>8/27/60</u> M, from the causes and on the date stated above. ACTUAL SIGNATURE <u>Wm. Toole</u> M.D. <u>Johns Hopkins Hosp</u> ADDRESS (Street, city or town, state) <u>8/29/60</u> DATE SIGNED PHYSICIAN'S NAME (Type) <u>WM. NISBET TOOLE MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 1, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Magothy Church Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Pasadena, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William A. Jackson Funeral Home Inc.</u>				ADDRESS <u>916 Pa. Ave</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 2 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>			

08687

CERTIFICATE OF DEATH

8740

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may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director. All pages of this certificate should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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8708  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
08698

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>6 hours</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Elmer</b> MIDDLE <b>JOHN W.</b> LAST <b>ELMER ENSOR</b>		4. DATE OF DEATH Month <b>August</b> Day <b>24</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 2, 1886</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months <b>7</b> Days <b>24</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Samuel Lloyd Ensor</b>		14. MOTHER'S MAIDEN NAME <b>Eleanor Harman</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-01-1841</b>	
17. INFORMANT <b>Mrs. Gertrude Ensor</b>		Address <b>Severna Park, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ruptured aneurysm, st.</b> 452X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>close artery</b> DUE TO (c) <b>arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>(deceased)</b> attended the deceased from <b>Aug. 24, 19 60</b> to <b>Aug. 24, 19 60</b> , that (I) <b>(he)</b> last saw the deceased alive on <b>Aug. 24, 19 60</b> , and that death occurred on <b>Aug. 24, 19 60</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Frank M. Shipley</b>		22b. DATE SIGNED <b>8/24/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Frank M. Shipley</b>		22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 27, 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		23d. LOCATION (City, town, or county) (State) <b>Pikesville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Burgee Funeral Home</b>		25a. REC'D BY REGISTRAR <b>Aug 26 60</b>	
25b. REGISTRAR'S SIGNATURE <b>Carroll S. Knisk</b>		25c. ADDRESS <b>3631 Falls Road</b>	

26030



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. This certificate is to be used for the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
08699

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>9 hours</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				e. STREET ADDRESS <b>RURAL - Harwood</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Grace</b> Middle <b>EVANS</b> Last <b>EVANS</b>				4. DATE OF DEATH Month <b>August</b> Day <b>8</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>October 11, 1901</b>	
9. AGE (In years last birthday) <b>58</b> yrs.		IF UNDER 1 YEAR Months <b>58</b> Days <b>58</b> Hours <b>58</b> Min.		IF UNDER 24 HRS. Months <b>58</b> Days <b>58</b> Hours <b>58</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>Albert Hall</b>				14. MOTHER'S MAIDEN NAME <b>Chanty Hall</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>111-11-1111</b>			
17. INFORMANT <b>Alice Evans Davidson</b>				Address <b>111-11-1111</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> DUE TO <b>Hypertension and arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension and arteriosclerosis</b> DUE TO <b>Hypertension and arteriosclerosis</b> (c) <b>Hypertension and arteriosclerosis</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>No</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>11:12 A.M.</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 8, 1960</b> to <b>Aug. 8, 1960</b> , that (I) <b>was</b> last saw the deceased alive on <b>Aug. 8, 1960</b> , and that death occurred at <b>11:12 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>A. T. Allen</b>				22b. DATE SIGNED <b>11:12 A.M.</b>			
22c. PHYSICIAN'S NAME (Type) <b>A. T. Allen</b>				22d. ADDRESS <b>62 Cathedral St., Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>8-12-1960</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Adams</b>				23d. LOCATION (City, town, or county) (State) <b>Lothian Md.</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese</b>				25a. REC'D BY REGISTRAR <b>Anna</b>			
25b. REGISTRAR'S SIGNATURE <b>Anna</b>				DATE <b>AUG 12 '60</b>			

MEDICAL CERTIFICATION

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CERTIFICATE OF MARRIAGE

2708

(M)

WITNESSES

Minister

Minister

and Minister of the Gospel

Witness

Witness

Witness

Witness

Witness

Witness

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## CERTIFICATE OF DEATH

Reg. Dist. No. 08700

8747

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. LENGTH OF STAY IN 1b <b>13 yr. 8mo. 28 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>1321 Eutaw Place</b>			
3. NAME OF DECEASED (Type or print) First <b>Anna</b> Middle <b>Fleet</b> Last <b>Fleet</b>				4. DATE OF DEATH Month <b>8</b> Day <b>29</b> Year <b>19 60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 29, 1906</b>	
9. AGE (In years lost birthday) <b>54</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Factory</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Augusta Fleet</b>				14. MOTHER'S MAIDEN NAME <b>Ada Murray</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peritoneal Carcinomatosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma of Ovary</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>			
20c. TIME OF INJURY Hour <b>9</b> p. m. Month <b>8</b> Day <b>19</b> Year <b>19 60</b>		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> While not at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, etc.) <b>-----</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6/3</b> , 19 <b>46</b> , to <b>8/29</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>8/29</b> , 19 <b>60</b> , and that death occurred at <b>7:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>8/30/60</b> ACTUAL SIGNATURE <b>L. Benedict, M. D.</b> M.D. <b>Crownsville State Hospital, Md.</b> <b>8/30/60</b> PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b> <b>Crownsville State Hospital, Md.</b> <b>8/30/60</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-2-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>A. A. County, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Milton E. Glickman</b>				24a. REC'D BY REGISTRAR <b>N. Carolina St.</b>		24b. REGISTRAR'S SIGNATURE <b>August 31 '60</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

06530

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8710

## CERTIFICATE OF DEATH

Reg. Dist. No. 08701

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>60 Glen Burnie</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen'l. Hosp.</u>				d. STREET ADDRESS <u>1 10 Virginia Ave., N.W.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Ernest</u> Middle <u>H.</u> Last <u>Frank</u>				4. DATE OF DEATH Month <u>August</u> Day <u>21</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>24<sup>th</sup> March 1913</u>	
9. AGE (In years last birthday) <u>47</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>7</u> Hours <u>13</u> Min.		IF UNDER 24 HRS. Months <u>4</u> Days <u>7</u> Hours <u>13</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Harry R. Frank</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Fleagle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>WWII</u>				16. SOCIAL SECURITY NO. <u>21805-1454</u>		17. INFORMANT <u>Mrs. Ernest Frank</u> Address <u>Glen Burnie, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma of colon</u> DUE TO <u>153.8</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2/31</u> , 19 <u>60</u> , to <u>8/21</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8/21</u> , 19 <u>60</u> , and that death occurred at <u>2:30</u> P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>121 Cathedral</u> DATE SIGNED <u>8/21/60</u> ACTUAL SIGNATURE <u>Philip H. Hedeman</u> M.D. <u>Annapolis, Md.</u> PHYSICIAN'S NAME (Type) <u></u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>24 Aug. 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Madowridge Mem. Pk.</u>		22d. LOCATION (City, town, or county) (State) <u>Howard Co., Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. P. Singleton</u> ADDRESS <u>Glen Burnie, Md.</u>				24a. REC'D BY REGISTRAR <u>AUG 23 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Anthony J. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8748

## CERTIFICATE OF DEATH

Reg. Dist. No. 08702

1. PLACE OF DEATH a. COUNTY <i>Denne aundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>D. C.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>North Beach Park</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i> 47X-2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>no</i>		d. STREET ADDRESS <i>4412 Lowell St. N.W.</i>	
3. NAME OF DECEASED (Type or print) First <i>James</i> Middle <i>Howard</i> Last <i>Fitz</i>		4. DATE OF DEATH Month <i>August</i> Day <i>23</i> Year <i>1960</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>December 6, 1884</i>
9. AGE (In years, lost birthday) <i>75 yrs.</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>8</i> Days <i>17</i> Hours <i>17</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Engineer Navy Ordnance (Retired)</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
11. BIRTHPLACE (State or foreign country) <i>Washington, D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Fredrick Fitz</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Howard</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>Under Navy Ord. Service</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Elizabeth Fitz</i>		Address <i>4412 Lowell St. Wash. D.C.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>arteriosclerosis</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Prostatectomy May 1960</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>no</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>no</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>not at all</i> , to <i>19</i> , that I last saw the deceased alive on <i>19</i> , and that death occurred at <i>8 A.M.</i> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>Washington, Md.</i> DATE SIGNED <i>8-23-60</i>			
ACTUAL SIGNATURE <i>Emily H. Wilson</i> M.D. <i>Lothman, Md.</i>		PHYSICIAN'S NAME (Type) <i>(Deputy Coroner -)</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>8-26-60</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>MT. OLIVET</i>		22d. LOCATION (City, town, or county) (State) <i>WASH. D.C.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Simon Bros.</i>		24a. REC'D BY REGISTRAR <i>1661-Good Hope Rd SE WASH 2000</i>	
24b. REGISTRAR'S SIGNATURE <i>Carlton S. Kline</i>		DATE <i>AUG 25 '60</i>	

CERTIFICATE OF DEATH

88708

<p>1. NAME OF DECEASED                  [Faint text, possibly "JOHN DOE"]</p>		<p>2. SEX                  [Faint text, possibly "Male"]</p>		<p>3. AGE                  [Faint text, possibly "45"]</p>		<p>4. DATE OF BIRTH                  [Faint text, possibly "10/15/1910"]</p>		<p>5. PLACE OF BIRTH                  [Faint text, possibly "Baltimore, Md"]</p>	
<p>6. OCCUPATION                  [Faint text, possibly "Teacher"]</p>		<p>7. MARITAL STATUS                  [Faint text, possibly "Married"]</p>		<p>8. DATE OF DEATH                  [Faint text, possibly "11/1/1955"]</p>		<p>9. TIME OF DEATH                  [Faint text, possibly "10:30 AM"]</p>		<p>10. PLACE OF DEATH                  [Faint text, possibly "Home"]</p>	
<p>11. CAUSE OF DEATH                  [Faint text, possibly "Heart Disease"]</p>		<p>12. MANNER OF DEATH                  [Faint text, possibly "Natural"]</p>		<p>13. SIGNATURE OF PHYSICIAN                  [Faint signature]</p>		<p>14. SIGNATURE OF REGISTRAR                  [Faint signature]</p>		<p>15. DATE OF REGISTRATION                  [Faint text, possibly "11/1/1955"]</p>	
<p>16. PLACE OF BURIAL                  [Faint text, possibly "St. Mary's Cemetery"]</p>		<p>17. NAME OF CEMETERY                  [Faint text, possibly "St. Mary's"]</p>		<p>18. NAME OF MINISTER                  [Faint text, possibly "Rev. J. Smith"]</p>		<p>19. NAME OF CHURCH                  [Faint text, possibly "St. Mary's Church"]</p>		<p>20. DATE OF BURIAL                  [Faint text, possibly "11/1/1955"]</p>	

2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
08703

1. PLACE OF DEATH o. COUNTY <u>HAN HRUNDO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>HAN HRUNDO</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Glen Burnie, Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - Glen Burnie, Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Bldg 1243 W. L. Thompson</u>		d. STREET ADDRESS <u>Same</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>MARY Cecelia Goddard</u>		4. DATE OF DEATH <u>August 17</u> 19 <u>60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 30 1897</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR <u>—</u> Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William S. Burns</u>		14. MOTHER'S MAIDEN NAME <u>Annie C. Schramm</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Helen Spurrer</u>		Address <u>215 Northshire Baltimore, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 331X DUE TO <u>Cerebral arterio sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. DUE TO <u>Diabetes Mellitus</u>		INTERVAL BETWEEN ONSET AND DEATH <u>104 yrs.</u> <u>3 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>—</u> p. m. <u>—</u> 19 <u>60</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/4</u> 19 <u>57</u> to <u>8/17</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>8/17</u> 19 <u>60</u> , and that death occurred at <u>1:30</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>R. W. Prichard</u>		22b. DATE SIGNED <u>8/17/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>R. W. PRICHARD</u>		22d. ADDRESS <u>Glen Burnie, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Aug 22, 1960</u>		23b. DATE THEREOF <u>Aug 22, 1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Soudon Park</u>		23d. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edmund H. Nash</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Kraus</u>	
ADDRESS <u>1111 E. Belvedere Ave. Balto. Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

08303

DEPARTMENT OF DEATH

2842

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1011 11/11

General George, Mrs. Jackson, Fort  
Thompson, Tenn., 1116 11/11  
11/11 11/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: Although this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be given to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8750

CERTIFICATE OF DEATH

Reg. Dist. No. 08704

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. LENGTH OF STAY IN 1b <b>4mo. 1 year 12 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frederick</b> <b>1011-2</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>Unknown</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>Homer</b> Last <b>Gray</b>				4. DATE OF DEATH Month <b>8</b> Day <b>22</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 29, 1887</b>	
				9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Henry Dorsey</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca Gray</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-09-7936</b>		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia, Decubital Ulcers</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardiovascular Disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>					
20c. TIME OF INJURY Hour a. m. <b>-----</b> p. m. <b>-----</b> Month <b>-----</b> Day <b>19</b> Year <b>19</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/10</b> , 19 <b>59</b> , to <b>8/22</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>8/22</b> , 19 <b>60</b> , and that death occurred at <b>7:30 A.</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Hildegard Heard Reissmann</b> M.D. <b>Crownsville State Hospital, Md. 8/22/60</b> PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissmann, M. D. Crownsville State Hospital, Md. 8/22/60</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>8/24/60</b>		22c. PLACE OF BURIAL, CREMATION, REMOVAL <b>Unity of Baltimore</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Reese</b>				ADDRESS <b>108 W. W. Way</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 26 60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knap</b>			







## CERTIFICATE OF DEATH

Reg. Dist. No. 08705

8751

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Upper Marlboro</b>			
c. LENGTH OF STAY IN 1b <b>8 yrs.</b>				d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>			
d. STREET ADDRESS <b>Unknown</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Elizabeth</b> Middle <b>Green</b> Last <b>Green</b>				4. DATE OF DEATH Month <b>8</b> Day <b>3</b> Year <b>1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 4, 1886</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housework</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph Green</b>				14. MOTHER'S MAIDEN NAME <b>Sarah ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardiovascular Disease</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Parkinson's Disease</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Month, Day, Year Hour a. m. ----- p. m. -----		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>2/6</b> , 19 <b>52</b> , to <b>8/3</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>8/3</b> , 19 <b>60</b> , and that death occurred at <b>7:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>8/3/60</b>							
ACTUAL SIGNATURE <i>[Signature]</i>				M.D. <b>Crownsville State Hospital, Md.</b> <b>8/3/60</b>			
PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>				<b>Crownsville State Hospital, Md.</b> <b>8/3/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>8-8-60</b>		22b. DATE THEREOF <b>Woodmore</b>		22c. NAME OF CEMETERY OR CREMATORY <b>P. Geo. Co. Md.</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. S. Washington</b>				24a. REC'D BY REGISTRAR <b>4925 Deane</b>		24b. REGISTRAR'S SIGNATURE <b>DATE AUG 11 '60</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

83708

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]		DATE OF BIRTH [Illegible]	
PLACE OF BIRTH [Illegible]		OCCUPATION [Illegible]		MARITAL STATUS [Illegible]		COLOR [Illegible]	
PLACE OF DEATH [Illegible]		CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]		DATE OF DEATH [Illegible]	
TIME OF DEATH [Illegible]		PLACE OF INTERMENT [Illegible]		NAME OF FUNERAL HOME [Illegible]		NAME OF MINISTER [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF CLERK [Illegible]	
DATE OF SIGNATURE [Illegible]		DATE OF SIGNATURE [Illegible]		DATE OF SIGNATURE [Illegible]		DATE OF SIGNATURE [Illegible]	

THIS CERTIFICATE IS VALID FOR THE PURPOSE OF RECORDING AND STATISTICAL PURPOSES ONLY. IT IS NOT VALID FOR ANY OTHER PURPOSE. THE STATE DEPARTMENT OF HEALTH IS NOT RESPONSIBLE FOR THE ACCURACY OF THE INFORMATION PROVIDED HEREON.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon bands. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
8711  
CERTIFICATE OF DEATH  
08706

1. PLACE OF DEATH a. COUNTY <u>aa</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>94 Shipwright St</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>aa</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis 10</u> d. STREET ADDRESS <u>94 Shipwright</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Louis</u> First <u>Harwood</u> Middle <u>Green</u> Last 4. DATE OF DEATH <u>Aug</u> Month <u>27</u> Day <u>1960</u> Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>2-19-1880</u> 9. AGE (In years less birthday) <u>80</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u> 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Louis H. Green</u> 14. MOTHER'S MAIDEN NAME <u>Margaret Isaac</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. <u>-</u> 17. INFORMANT <u>L. Harwood Green Jr.</u> Address <u>(2)</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> <u>715X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bed sore infection</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebro vascular disease</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>AUG 13<sup>th</sup></u> 19 <u>60</u> , to <u>AUG 27<sup>th</sup></u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>AUG 27<sup>th</sup></u> 19 <u>60</u> , and that death occurred at <u>9 P.</u> M. from the causes and on the date stated above. 22a. SIGNATURE <u>Gerard Chureti</u> 22b. DATE SIGNED <u>AUG 29<sup>th</sup> 1960</u> 22c. PHYSICIAN'S NAME (Type) <u>GERARDO CHURETI</u> 22d. ADDRESS <u>121 CATHEDRAL ST ANNAPOLIS</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Aug 30-1960</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u> 23d. LOCATION (City, town, or county) (State) <u>Annapolis md</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sr</u> ADDRESS <u>Annapolis md</u> 25a. REC'D BY REGISTRAR DATE <u>SEP 1 '60</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

1. Name of deceased *John J. Smith*  
2. Age *45*  
3. Sex *Male*  
4. Date of death *Jan 15 1900*  
5. Place of death *at home*  
6. Cause of death *Heart disease*  
7. Signature of physician *J. H. Smith*  
8. Signature of witness *J. H. Smith*  
9. Signature of registrar *J. H. Smith*  
10. Signature of coroner *J. H. Smith*  
11. Signature of undertaker *J. H. Smith*  
12. Signature of funeral home *J. H. Smith*  
13. Signature of cemetery *J. H. Smith*  
14. Signature of church *J. H. Smith*  
15. Signature of family *J. H. Smith*  
16. Signature of friends *J. H. Smith*  
17. Signature of neighbors *J. H. Smith*  
18. Signature of community *J. H. Smith*  
19. Signature of country *J. H. Smith*  
20. Signature of world *J. H. Smith*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: All this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
8712

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08707

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Wheeler</u> Middle <u>B.</u> Last <u>Green</u>				4. DATE OF DEATH Month <u>8</u> Day <u>14</u> Year <u>1960</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-24-1907</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		10. IF UNDER 1 YEAR Months <u>3</u> Days <u>14</u> Hours <u>19</u> Min.		11. IF UNDER 24 HRS. Hours <u>19</u> Min.		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Heating &amp; Plumbing</u>			
11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Lee Green</u>				14. MOTHER'S MAIDEN NAME <u>Julia Barber</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Boris D. Green</u> Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>Coronary artery disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary artery disease, hepatic failure</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 13<sup>th</sup> 1960</u> to <u>Aug 14<sup>th</sup> 1960</u> , that (I) (we) lost the deceased on <u>Aug 14<sup>th</sup> 1960</u> , and that death occurred on <u>Aug 14<sup>th</sup> 1960</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>G. Church M.D.</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>GERARD CHURCH</u>				22d. ADDRESS <u>121 CATHEDRAL ST.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-17-1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Leo Co</u>		23d. LOCATION (City, town, or county) (State) <u>md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons Annapolis Md.</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 18 '60</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>							

02707

CERTIFICATE OF DEATH

8512

Full Name of Deceased

Age

Sex

Marital Status

Occupation

Place of Birth

Date of Death

Time of Death

Place of Death

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Police Officer

Signature of Funeral Home

Signature of Burial Society

Signature of Cemetery

Signature of Other

Witnesses

1



1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8752 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08708											
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Same</u>						
c. LENGTH OF STAY IN 1b <u>6 Y.</u>					d. STREET ADDRESS <u>Same</u>						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Box 139</u>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>Benjamin Wellington Guinn</u>					4. DATE OF DEATH Month <u>August</u> Day <u>20th</u> Year <u>1960</u>						
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/12/10</u>		9. AGE (In years last birthday) <u>49</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>					10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Dickson City Pa.</u>		12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>Edward Guinn</u>					14. MOTHER'S MAIDEN NAME <u>Anna Hall</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					16. SOCIAL SECURITY NO.					17. INFORMANT <u>Mrs. Ruby Guinn</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute posterior occlusion, myocardial infarction</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Gustave H. Faubert, M.D.</u>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>					DATE SIGNED <u>8/22/60</u>	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						
					Address (Street, city, town, or county)						
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>8/24/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>			22d. LOCATION (City, town, or country) (State) <u>Glen Burnie Md.</u>			
23. FUNERAL DIRECTOR <u>Hopping and Kirkley</u>					ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 23 '60</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

88708

8858

100-2011



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 8753 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08709  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorsey</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Dorsey, Md 176</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Harmons</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Dorsey Rd #176, 1000 W. W. Express</u>			d. STREET ADDRESS <u>Box 112 c Dorsey Rd</u>		
3. NAME OF DECEASED (Type or print) <u>RUFUS</u> First Middle Last			4. DATE OF DEATH <u>8/27/1960</u> Month Day Year		
5. SEX <u>M</u>		6. COLOR OR RACE <u>an</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>July 20, 1915</u>		9. AGE (in years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laboren</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Md.</u>		
11. BIRTHPLACE (State or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <u>R. N. Kwon</u>			14. MOTHER'S MAIDEN NAME <u>Ethel Hall</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>1944 Ridgehill Dr</u>		
17. INFORMANT <u>William N. Hall</u> Address			18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Massive facial skull fractures</u> DUE TO <u>983X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>983X</u> DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>Apparently hit-run</u>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year <u>9:15 a.m. 8/27 1960</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>W. Bradley King Jr</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>W. Bradley King Jr, MD</u>			ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			DATE SIGNED <u>8/28/60</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/31/1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Saints Rest Cem.</u>	
22d. LOCATION (City, town, or county) <u>Harmons Md.</u>		22e. (State)		22f. (City, town, or county)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. R. Williams</u>			ADDRESS <u>322 N. Schroeder St.</u>		
24a. REC'D BY REGISTRAR <u>8/28/60</u>			24b. REGISTRAR'S SIGNATURE <u>William R. Williams</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

00529

TO HOSPITAL OR ATTENDING-PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

1

8754

Item 9 Film 6269 8-19-60 et

8754

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

08710

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> COUNTY <u>W. A.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>St. 1 Boy 146</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William</u> First <u>Hall</u> Middle <u>Hall</u> Last <u>Hall</u>		4. DATE OF DEATH <u>8</u> Month <u>11</u> Day <u>1960</u> Year	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Col.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-2-1881</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Hall</u>		14. MOTHER'S MAIDEN NAME <u>Isabel Hall</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>248-12-9402A</u>	
17. INFORMANT <u>Alice Hall - Annapolis, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Cardio-Vascular Disease</u> DUE TO (c) <u>General Atherosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24hr</u> <u>10 yrs</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/11</u> , 19 <u>60</u> , to <u>8/11</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8/11</u> , 19 <u>60</u> , and that death occurred at <u>3:30 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Theodore H. Johnson M.D.</u>		ADDRESS (Street, city or town, state) <u>37 Calvert St.</u>	
PHYSICIAN'S NAME (Type) <u>THEODORE H. JOHNSON M.D.</u>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-14-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fowlers</u>		22d. LOCATION (City, town, or county) (State) <u>Best Gate, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, II - Annap. Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>AUG 17 60</u>		24b. REGISTRAR'S SIGNATURE <u>John S. Henshaw</u>	

02730

CERTIFICATE OF DEATH

8558



*[Faint, mostly illegible text, likely a death certificate form with fields for name, date, and cause of death.]*



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

08711

8755

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. LENGTH OF STAY IN 1b <b>3 years</b> <b>10mo. 23 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				e. STREET ADDRESS <b>2316 Hunter Street</b>			
3. NAME OF DECEASED (Type or print) First <b>Lizzie</b> Middle <b>Hampton</b> Last <b>Hampton</b>				4. DATE OF DEATH Month <b>8</b> Day <b>15</b> Year <b>1960</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1881?</b>		9. AGE (In years last birthday) <b>79?</b> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Unknown</b>			14. MOTHER'S MAIDEN NAME <b>Unknown</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO <b>443X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Hypertensive Cardiovascular Disease</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Senility</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>				
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year ----- 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>9/22</b> , 19 <b>56</b> , to <b>8/15</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>8/15</b> , 19 <b>60</b> , and that death occurred at <b>2:30P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Hildegard Heard Reissmann</b> M.D. <b>Crownsville State Hospital, Md.</b> <b>8/16/60</b>							
ACTUAL SIGNATURE <b>Hildegard Heard Reissmann</b>							
PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissmann, M. D.</b> <b>Crownsville State Hospital, Md.</b> <b>8/16/60</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF PERSON TO WHOM TURNED OVER		22d. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>8/22/60</b>		<b>City of Baltimore</b>		<b>Baltimore Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm Russell</b>				ADDRESS <b>15th W Ward</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 26 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kneale</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be given to the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8



1  
Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: All of this certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filled with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
8756  
CERTIFICATE OF DEATH

08712

1. PLACE OF DEATH a. COUNTY <i>a. a.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>a. a.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>By Water Road</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>X By Water Road</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Annapolis Md R. F. D.</i>		d. STREET ADDRESS <i>Annapolis M. R. F. D.</i>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>Preston</i> Last <i>HARRISON SR</i>		4. DATE OF DEATH Month <i>Aug</i> Day <i>30</i> Year <i>1960</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Sept 25 - 1885</i>
9. AGE (In years last birthday) <i>74</i> yrs.		10. IF UNDER 1 YEAR Months <i>7</i> Days <i>4</i> Hours <i>15</i> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Tobacco</i>	
11. BIRTHPLACE (State or foreign country) <i>Calvert Co Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>William Henry Harrison</i>		14. MOTHER'S MAIDEN NAME <i>Sarah Elizabeth Watson</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Grace S. Harrison</i>		Address <i>#2</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CEREBRAL THROMBOSIS</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under</u> lying cause last. (b) <i>ARTERIOSCLEROSIS</i> DUE TO (c) <i>—</i>		INTERVAL BETWEEN ONSET AND DEATH <i>5 DAYS</i> <i>10 YRS</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>HYPERTENSIVE HEART DISEASE</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>8/22 1960</i> to <i>8/30 1960</i> , that (I) (we) last saw the deceased alive on <i>8/28 1960</i> , and that death occurred at <i>—</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Edward S. Beck</i>		22b. DATE SIGNED <i>8/31/60</i>	
22c. PHYSICIAN'S NAME (Type) <i>Edward S. BECK</i>		22d. ADDRESS <i>71 Franklin St., Annapolis, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Sept 2 - 1960</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Glen Haven Cemt</i>		23d. LOCATION (City, town, or county) (State) <i>Glen Burnie Md</i>	
24. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>		25a. REC'D BY REGISTRAR DATE <i>SEP 2 '60</i>	
ADDRESS <i>Annapolis Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>	

08713

COMPANY OF CHINA

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Pages 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

8757

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08713

<p>1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u></p>				<p>2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Same</u> COUNTY <u>Same</u></p>			
<p>b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u></p>				<p>c. LENGTH OF STAY IN 1b <u>8 years</u></p>			
<p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>413 Magnolia Road</u></p>				<p>d. STREET ADDRESS <u>Same</u></p>			
<p>3. NAME OF DECEASED (Type or print) First <u>LILLIAN</u> Middle <u>G.</u> Last <u>HOLLINS</u></p>				<p>4. DATE OF DEATH Month <u>August</u> Day <u>30th</u> Year <u>19 60</u></p>			
<p>5. SEX <u>F</u></p>		<p>6. COLOR OR RACE <u>W</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>7/11/89</u></p>	
<p>9. AGE (In years last birthday) <u>71</u> yrs.</p>		<p>IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u></p>		<p>IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u></p>		<p>e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u></p>				<p>10b. KIND OF BUSINESS OR INDUSTRY <u>  </u></p>		<p>11. BIRTH PLACE (State or foreign country) <u>baltimore Md.</u></p>	
<p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p>				<p>13. FATHER'S NAME <u>William Akers</u></p>			
<p>14. MOTHER'S MAIDEN NAME <u>Jennie Browning</u></p>				<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>  </u></p>			
<p>16. SOCIAL SECURITY NO. <u>  </u></p>				<p>17. INFORMANT <u>Mrs. Harry S. Wright - 413 Magnolia Rd.</u></p>			
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cronary Occlusion</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>  </u> (c) <u>  </u></p>						<p>INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u></p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u></p>							
<p>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</p>				<p>20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u></p>			
<p>20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u></p>		<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u></p>		<p>20f. (City or town) (County) (State) <u>  </u></p>	
<p>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p>							
<p>ACTUAL SIGNATURE <u>Gustave H. Faubert</u></p>				<p>CHIEF MEDICAL EXAMINER <input type="checkbox"/></p>			
<p>EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u></p>				<p>M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/></p>			
<p>DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>  </u></p>				<p>DATE SIGNED <u>8/30/60</u></p>			
<p>Address (Street, city, town, or county) <u>  </u></p>				<p>22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u></p>			
<p>22b. DATE THEREOF <u>9/2/60</u></p>				<p>22c. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u></p>			
<p>22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u></p>				<p>24a. REC'D BY REGISTRAR DATE <u>AUG 31 '60</u></p>			
<p>24b. REGISTRAR'S SIGNATURE <u>  </u></p>				<p>24c. REGISTRAR'S SIGNATURE <u>  </u></p>			

MEDICAL CERTIFICATION

2

17. Med

81780





1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
8758 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
08714											
1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <b>Md.</b> b. COUNTY <b>A.A.</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort Meade</b>						c. LENGTH OF STAY IN 1b <b>2 hours</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Donohue Baseball Field</b>						d. STREET ADDRESS <b>Gambrills</b> <b>Waugh Chapel Rd.</b>					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>Paul I. Honor, III</b>						4. DATE OF DEATH Month <b>8</b> Day <b>22</b> Year <b>1960</b>					
5. SEX <b>M</b>						6. COLOR OR RACE <b>W</b>					
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						8. DATE OF BIRTH <b>1/19/32</b>					
9. AGE (In years last birthday) <b>28</b> yrs.						10. IF UNDER 1 YEAR Months <b>11</b> Days <b>3</b>					
11. IF UNDER 24 HRS. Hours <b>11</b> Min. <b>3</b>											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician</b>						10b. KIND OF BUSINESS OR INDUSTRY <b>Civil Service</b>					
11. BIRTHPLACE (State or foreign country) <b>Washington, D.C.</b>						12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Paul I. Honor Jr.</b>						14. MOTHER'S MAIDEN NAME <b>Mary C. Friedrichs</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>Yes</b> <b>ROMAN</b>						16. SOCIAL SECURITY NO. <b>Unknown</b>					
17. INFORMANT <b>Mrs. Mary C. Friedrichs (Mother)</b>						Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Electrocution</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>714.4</b> (b) (c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Apparently touched (live) wire while on light pole</b>					
20c. TIME OF INJURY Month, Day, Year <b>9:50 a.m. 8/22 1960</b>						20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Baseball Field</b>						20f. (City or town) (County) (State) <b>Anne Arundel Md.</b>					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>W. Bradley King, Jr., M.D.</b>						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <b>W. Bradley King, Jr., M.D.</b>						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED <b>8/23/60</b>					
Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>						22b. DATE THEREOF <b>26th Aug. 1960</b>					
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l. Cem.</b>						22d. LOCATION (City, town, or country) (State) <b>Fort Meyer, Virginia</b>					
23. FUNERAL DIRECTOR <b>Glen Burnie, Md.</b>						24a. REC'D BY REGISTRAR <b>AUG 26 '60</b>					
24b. REGISTRAR'S SIGNATURE <b>Glen Burnie, Md.</b>											



1  
FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH													
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
8713 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 08715													
Items 13, 14, 23 Film G271 9-19-60 et													
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Md. b. COUNTY A.A.							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pasadena							
c. LENGTH OF STAY IN 1b 1 hour						d. STREET ADDRESS Box 262 A, Old Annap. Rd.							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Anne Arundel						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Robert E. Ingle						4. DATE OF DEATH Month Day Year Aug 1 1960							
5. SEX Male		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7-11-60		9. AGE (In years last birthday) yrs. 20		IF UNDER 1 YEAR Months Days 20			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Home				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Md. Baltimore		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME Robert Ingle						14. MOTHER'S MAIDEN NAME Marlene Brenneman							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO.		17. INFORMANT Family - SAME					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 754.5 DUE TO (b) Congenital heart disease & Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) Congestive heart failure PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												INTERVAL BETWEEN ONSET AND DEATH Immediate 3 weeks	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE Willard F. Smith M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) DATE SIGNED 8/1/60													
22a. BURIAL, CREMATION, REMOVAL (Specify) B		22b. DATE THEREOF 8-3-60		22c. NAME OF CEMETERY OR CREMATORY Western Cem.				22d. LOCATION (city, town, or county) Baltimore, Md.					
23. FUNERAL DIRECTOR McCully Funeral Home 130 E. Fort Ave 24th													
24a. REC'D BY REGISTRAR						24b. REGISTRAR'S SIGNATURE							

VS. A15ME  
5M 7/59

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(11)

*[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page. Some words like "Robert" and "Table" are faintly visible.]*

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8714  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08716

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>18</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Cora</b> Middle <b>JACKSON</b> Last <b>JACKSON</b>		4. DATE OF DEATH Month <b>August</b> Day <b>30</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 15, 1926</b>
9. AGE (In years last birthday) <b>34</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Kitchen supervisor</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>	
11. BIRTHPLACE (State or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John Edward</b>		14. MOTHER'S MAIDEN NAME <b>Mammie L. Edward</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>112-</b>	
17. INFORMANT <b>112-</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pulmonary Edema</b> <b>645.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Exsanguination</b> (c) <b>Ruptured Aortic Popliteal Artery</b>			INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the physician) attended the deceased from <b>Aug. 22, 1960</b> to <b>Aug. 30, 1960</b> , that (I) (the physician) last saw the deceased alive on <b>Aug. 30, 1960</b> , and that death occurred at <b>11:15 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>R. L. Richardson</b>		22b. DATE SIGNED <b>8/31/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>R. L. Richardson</b>		22d. ADDRESS <b>110 Clay St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9-5-60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Prestwick</b>		23d. LOCATION (City, town or county) (State) <b>Prestwick, Ala.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>James H. Johnson</b>		25a. REC'D BY REGISTRAR <b>SEP 1 '60</b>	
ADDRESS <b>Annapolis, Md</b>		25b. REGISTRAR'S SIGNATURE <b>Charles L. Kraus</b>	

08716

CERTIFICATE OF DEATH

08716

John Edward

1912

John Edward

1912

1912

1912

John Edward

1912

John Edward  
1912

John Edward



MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8759

08717

Items 11, 12, 13, 14 File # 6270 9-6-60

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Michigan</b> b. COUNTY <b>✓</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fort George G. Meade</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Battle Creek</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>United States Army Hospital</b>				d. STREET ADDRESS <b>513 Jackson</b> <b>59X-3</b>			
3. NAME OF DECEASED (Type or print) First <b>JOSEPH</b> Middle <b>G</b> Last <b>JACKSON JR</b>				4. DATE OF DEATH Month <b>August</b> Day <b>16</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>20 May 1933</b>	
9. AGE (In years last birthday) <b>27</b> yrs.		IF UNDER 1 YEAR Months <b>27</b> Days <b>27</b> Hours <b>27</b> Min.		IF UNDER 24 HRS. Months <b>27</b> Days <b>27</b> Hours <b>27</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Soldier</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Army</b>			
11. BIRTHPLACE (State or foreign country) <b>Chicago, Ill</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Joseph Jackson</b>				14. MOTHER'S MAIDEN NAME <b>Bessie Macklin</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>374-34-0902</b>			
17. INFORMANT <b>Personnel Records Ft Geo G. Meade, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septisemia</b> <b>913.9</b> DUE TO <b>Infected stab wound of chest</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>5 days</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Blood disorder Sickie Cell disease</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Stated he fell on piece of glass</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>Aug 11 60</b> p. m. <b>Unknown</b> 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> at work <input checked="" type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Unknown</b>				20f. (City or town) (County) (State) <b>Unknown</b>			
21. I certify that the deceased died from the causes and on the date stated above. that (I) last saw the deceased alive on <b>11:00PM 15 Aug 60</b> and that death occurred at <b>02:30 A</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Stanley Siegelman</b> M.D.				22b. DATE SIGNED <b>16 Aug 60</b>			
22c. PHYSICIAN'S NAME (Type) <b>STANLEY S. SIEGELMAN, Capt., M.C.</b>				22d. ADDRESS <b>USA Hosp Ft Geo G. Meade, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>				23b. DATE THEREOF <b>8/18/60</b>			
23c. NAME OF CEMETERY OR CREMATORY <b>Robbins Funeral Home</b>				23d. LOCATION (City, town, or county) (State) <b>Bloomingsdale, Michigan</b>			
24. FUNERAL DIRECTOR'S SIGNATURE <b>Carl B. Woberton</b>				25a. REC'D BY REGISTRAR <b>AUG 19 '60</b>			
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Hume</b>							

MEDICAL CERTIFICATION

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DEPARTMENT OF HEALTH

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8760

CERTIFICATE OF DEATH

08718  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>			c. LENGTH OF STAY IN 1b <b>11 yrs. 7mo. 18 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>10 Annapolis,</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>208 Clay Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Roger</b> Last <b>Johnson</b>		4. DATE OF DEATH Month <b>8</b> Day <b>10</b> Year <b>19 60</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/1/1887</b>	9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Odd Jobs</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Garrison Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Cecelia Travers</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/23</b> , 19 <b>47</b> , to <b>8/10</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>8/10</b> , 19 <b>60</b> , and that death occurred at <b>1:35 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>L. Benedict, M. D.</b> M.D. <b>Crownsville State Hospital, Md.</b> <b>8/10/60</b> PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b> <b>Crownsville State Hospital, Md.</b> <b>8/10/60</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-16-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pine Lawn</b>		22d. LOCATION (City, town, or county) (State) <b>Best Gate</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese, II</b>				ADDRESS <b>Annapolis, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>AUG 15 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>			

CERTIFICATE OF DEATH

8760

08514

<p>1. NAME OF DECEASED                  [REDACTED]</p>		<p>2. SEX                  [REDACTED]</p>	
<p>3. AGE                  [REDACTED]</p>		<p>4. DATE OF BIRTH                  [REDACTED]</p>	
<p>5. PLACE OF BIRTH                  [REDACTED]</p>		<p>6. OCCUPATION                  [REDACTED]</p>	
<p>7. MARITAL STATUS                  [REDACTED]</p>		<p>8. CAUSE OF DEATH                  [REDACTED]</p>	
<p>9. MEDICAL HISTORY                  [REDACTED]</p>		<p>10. DATE OF DEATH                  [REDACTED]</p>	
<p>11. PLACE OF DEATH                  [REDACTED]</p>		<p>12. SIGNATURE OF PHYSICIAN                  [REDACTED]</p>	
<p>13. SIGNATURE OF REGISTRAR                  [REDACTED]</p>		<p>14. SIGNATURE OF WITNESS                  [REDACTED]</p>	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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15M 9/55

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8761

CERTIFICATE OF DEATH

08719  
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. LENGTH OF STAY IN 1b <b>11 years 4mo. 29 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Vista</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>Route 1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Arthur</b> Middle <b>Leo</b> Last <b>Jones</b>				4. DATE OF DEATH Month <b>8</b> Day <b>29</b> , Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>December 18, 1918</b>	
9. AGE (In years lost birthday) <b>41</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Jones</b>				14. MOTHER'S MAIDEN NAME <b>Mary Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemoptysis</b> <b>002X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pulmonary Tuberculosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <b>19</b> Month <b>8</b> Day <b>29</b> Year <b>1960</b>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>Crownsville</b> (County) <b>Prince George's</b> (State) <b>Md.</b>				20g. (City or town) <b>Baltimore</b> (County) <b>Prince George's</b> (State) <b>Md.</b>			
21. I certify that I attended the deceased from <b>12/9</b> , <b>1946</b> , to <b>8/29</b> , <b>1960</b> , that I last saw the deceased alive on <b>8/29</b> , <b>1960</b> , and that death occurred at <b>9:28 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>8/30/60</b>							
ACTUAL SIGNATURE <b>Lionel McHenry Mapp, M. D.</b>				M.D. <b>Crownsville State Hospital, Md.</b> <b>8/30/60</b>			
PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>				M.D. <b>Crownsville State Hospital, Md.</b> <b>8/30/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>9/2/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Univ. of Md.</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese II</b> ADDRESS <b>1828 W. Washington St. Annapolis, Md.</b>				24a. REC'D BY REGISTRAR <b>SEP 6 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Charles S. Kraus</b>	

KARYLAND STATE DEPARTMENT OF HEALTH--BALTIMORE 18



8762

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>District of Columbia</b> b. COUNTY <b>Prince George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. LENGTH OF STAY IN 1b <b>29 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Crownsville State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH First <b>Joseph</b> Middle <b>Jones</b> Last <b>Jones</b>				5. DATE OF DEATH Month <b>8</b> Day <b>6</b> Year <b>19 60</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1895</b>	
9. AGE (In years lost birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months <b>65</b> Days <b>65</b> Hours <b>65</b> Min. <b>65</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>			
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Ada ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>War #1</b>		17. INFORMANT <b>Unknown</b>		Address <b>Hospital Records</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> DUE TO 44-3X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>-----</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>					
20c. TIME OF INJURY Hour <b>a. m.</b> <b>19</b> Month <b>-----</b> Day <b>-----</b> Year <b>19</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) (County) (State) <b>-----</b>	
21. I certify that I attended the deceased from <b>3/7</b> , 19 <b>31</b> , to <b>8/6</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>8/6</b> , 19 <b>60</b> , and that death occurred at <b>1:25 P.M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Hildegard Heard Reissmann</b>				ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>8/8/60</b>			
PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissmann, M. D.</b>				Crownsville State Hospital, Md. <b>8/8/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-11-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON BLVD ARLINGTON VA</b>		22d. LOCATION (City, town, or county) (State) <b>ARLINGTON VA</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN TRHINES Co</b>				ADDRESS <b>3015 12th</b>		24a. REC'D BY REGISTRAR <b>AUG 12 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur E. K...</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08730

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

## CERTIFICATE OF DEATH

8730

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. RACE White		5. PLACE OF BIRTH Maryland	
6. DATE OF DEATH April 15, 1945		7. TIME OF DEATH 10:30 AM		8. PLACE OF DEATH Home		9. CAUSE OF DEATH Heart Disease		10. MANNER OF DEATH Natural	
11. SIGNATURE OF DECEASED James H. Harris		12. SIGNATURE OF WITNESS John D. Smith		13. SIGNATURE OF PHYSICIAN Dr. J. H. Jones		14. SIGNATURE OF CLERK Mary E. White		15. SIGNATURE OF REGISTRAR John A. Brown	
16. DATE OF BIRTH April 15, 1880		17. TIME OF BIRTH 10:30 AM		18. PLACE OF BIRTH Maryland		19. CAUSE OF BIRTH Heart Disease		20. MANNER OF BIRTH Natural	
21. SIGNATURE OF DECEASED James H. Harris		22. SIGNATURE OF WITNESS John D. Smith		23. SIGNATURE OF PHYSICIAN Dr. J. H. Jones		24. SIGNATURE OF CLERK Mary E. White		25. SIGNATURE OF REGISTRAR John A. Brown	
26. DATE OF BIRTH April 15, 1880		27. TIME OF BIRTH 10:30 AM		28. PLACE OF BIRTH Maryland		29. CAUSE OF BIRTH Heart Disease		30. MANNER OF BIRTH Natural	
31. SIGNATURE OF DECEASED James H. Harris		32. SIGNATURE OF WITNESS John D. Smith		33. SIGNATURE OF PHYSICIAN Dr. J. H. Jones		34. SIGNATURE OF CLERK Mary E. White		35. SIGNATURE OF REGISTRAR John A. Brown	
36. DATE OF BIRTH April 15, 1880		37. TIME OF BIRTH 10:30 AM		38. PLACE OF BIRTH Maryland		39. CAUSE OF BIRTH Heart Disease		40. MANNER OF BIRTH Natural	
41. SIGNATURE OF DECEASED James H. Harris		42. SIGNATURE OF WITNESS John D. Smith		43. SIGNATURE OF PHYSICIAN Dr. J. H. Jones		44. SIGNATURE OF CLERK Mary E. White		45. SIGNATURE OF REGISTRAR John A. Brown	
46. DATE OF BIRTH April 15, 1880		47. TIME OF BIRTH 10:30 AM		48. PLACE OF BIRTH Maryland		49. CAUSE OF BIRTH Heart Disease		50. MANNER OF BIRTH Natural	
51. SIGNATURE OF DECEASED James H. Harris		52. SIGNATURE OF WITNESS John D. Smith		53. SIGNATURE OF PHYSICIAN Dr. J. H. Jones		54. SIGNATURE OF CLERK Mary E. White		55. SIGNATURE OF REGISTRAR John A. Brown	
56. DATE OF BIRTH April 15, 1880		57. TIME OF BIRTH 10:30 AM		58. PLACE OF BIRTH Maryland		59. CAUSE OF BIRTH Heart Disease		60. MANNER OF BIRTH Natural	
61. SIGNATURE OF DECEASED James H. Harris		62. SIGNATURE OF WITNESS John D. Smith		63. SIGNATURE OF PHYSICIAN Dr. J. H. Jones		64. SIGNATURE OF CLERK Mary E. White		65. SIGNATURE OF REGISTRAR John A. Brown	
66. DATE OF BIRTH April 15, 1880		67. TIME OF BIRTH 10:30 AM		68. PLACE OF BIRTH Maryland		69. CAUSE OF BIRTH Heart Disease		70. MANNER OF BIRTH Natural	
71. SIGNATURE OF DECEASED James H. Harris		72. SIGNATURE OF WITNESS John D. Smith		73. SIGNATURE OF PHYSICIAN Dr. J. H. Jones		74. SIGNATURE OF CLERK Mary E. White		75. SIGNATURE OF REGISTRAR John A. Brown	
76. DATE OF BIRTH April 15, 1880		77. TIME OF BIRTH 10:30 AM		78. PLACE OF BIRTH Maryland		79. CAUSE OF BIRTH Heart Disease		80. MANNER OF BIRTH Natural	
81. SIGNATURE OF DECEASED James H. Harris		82. SIGNATURE OF WITNESS John D. Smith		83. SIGNATURE OF PHYSICIAN Dr. J. H. Jones		84. SIGNATURE OF CLERK Mary E. White		85. SIGNATURE OF REGISTRAR John A. Brown	
86. DATE OF BIRTH April 15, 1880		87. TIME OF BIRTH 10:30 AM		88. PLACE OF BIRTH Maryland		89. CAUSE OF BIRTH Heart Disease		90. MANNER OF BIRTH Natural	
91. SIGNATURE OF DECEASED James H. Harris		92. SIGNATURE OF WITNESS John D. Smith		93. SIGNATURE OF PHYSICIAN Dr. J. H. Jones		94. SIGNATURE OF CLERK Mary E. White		95. SIGNATURE OF REGISTRAR John A. Brown	
96. DATE OF BIRTH April 15, 1880		97. TIME OF BIRTH 10:30 AM		98. PLACE OF BIRTH Maryland		99. CAUSE OF BIRTH Heart Disease		100. MANNER OF BIRTH Natural	

TENTH DAY

MAY 1945

MAY 1945

MAY 1945

MAY 1945

8763

## CERTIFICATE OF DEATH

08721

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. LENGTH OF STAY IN 1b <b>6mo. 9 years 1 day</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Maxwell</b> Middle <b>Major</b> Last <b>Jones</b>				4. DATE OF DEATH Month <b>8</b> Day <b>28</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 25, 1888</b>	
9. AGE (In years last birthday) yrs. <b>72</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Builder</b>		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Massachusetts</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Unknown</b>			
14. MOTHER'S MAIDEN NAME <b>Unknown</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <b>Unknown</b>				17. INFORMANT <b>Hospital Records</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----			
20c. TIME OF INJURY Hour <b>---</b> o. m. <b>---</b> p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----	
20f. (City or town) -----				20g. (County) -----		20h. (State) -----	
21. I certify that I attended the deceased from <b>2/27</b> , 19 <b>51</b> , to <b>8/28</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>8/28</b> , 19 <b>60</b> , and that death occurred at <b>4:44 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>8/29/60</b>							
ACTUAL SIGNATURE <b>Hildegard Heard Reissmann</b> M.D.				PHYSICIAN'S NAME (Type) <b>Hildegard Heard Reissmann, M. D. Crownsville State Hospital, Md.</b> <b>8/29/60</b>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>9-1-1960</b>		22c. NAME OF CEMETERY OR CREMATORY <b>SHARP STREET CEM.</b>		22d. LOCATION (City, town, or county) (State) <b>CHASE, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Milton E. Lichten</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 31 '60</b>		24b. REGISTRAR'S SIGNATURE <b>William L. P. Reed</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached and used as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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Page 4 of 5

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TSM 9/59

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death. The low requires that the death certificate be executed within 24 hours after death.

<div style="text-align: center;"> <b>MARYLAND STATE DEPARTMENT OF HEALTH</b>  <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>											
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Anne Arundel</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> c. LENGTH OF STAY IN 1b <b>10</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b> d. STREET ADDRESS <b>600 6th St.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Sarah</b> Middle <b>Catterton</b> Last <b>JONES</b>				<b>4. DATE OF DEATH</b> Month <b>August</b> Day <b>3</b> Year <b>19 60</b>							
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>April 15, 1894</b>		<b>9. AGE</b> (In years last birthday) <b>66</b> yrs.		<b>IF UNDER 1 YEAR</b> Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min. <b>66</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>	
<b>13. FATHER'S NAME</b> <b>Virgil Catterton</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>							
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Mrs Stewart Leitch</b>				Address <b>(2)</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>332X</b> IMMEDIATE CAUSE (a) <b>CEREBRAL THROMBOSIS</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) DUE TO (c)										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 DAYS</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>											
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <b>19</b>				<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>July 31, 19 60</b> , <b>to Aug. 3, 19 60</b> , that (I) <b>did</b> last saw the deceased alive on <b>Aug. 3, 19 60</b> , and that death occurred at <b>11:30 P.M.</b> M, from the causes and on the date stated above.											
<b>22a. SIGNATURE</b> <b>Edward S. Beck</b>				<b>22b. DATE SIGNED</b> <b>8/4/60</b>				<b>22c. PHYSICIAN'S NAME (Type)</b> <b>Edward S. Beck</b>			
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>8-6-1960</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Mt Zion Cemetery</b>		<b>23d. LOCATION (City, town, or county)</b> (State) <b>Mt Zion AAG Md</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>John M. Saylor Sons</b>				<b>25a. REC'D BY REGISTRAR</b> <b>Aug 8 '60</b>				<b>25b. REGISTRAR'S SIGNATURE</b> <b>Charles E. Hance</b>			

MEDICAL CERTIFICATION



08753

CONFIDENTIAL

8712

Area Director

Director

Area Director

Director

Director

Director

Area Director

Director

Director

Director

Director

Director

U.S.

Director

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Director

U.S.

Director

U.S. Department of Justice  
Federal Bureau of Investigation  
Washington, D.C. 20535



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8764

## CERTIFICATE OF DEATH

08723

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Linthicum</u>				c. LENGTH OF STAY IN 1b <u>yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>#435 Cleveland Road</u>				d. STREET ADDRESS <u>#435 Cleveland Rd.</u>			
3. NAME OF DECEASED (Type or print) First <u>WILLIAM</u> Middle <u>D.</u> Last <u>JOYNES</u>				4. DATE OF DEATH Month <u>Aug.</u> Day <u>18,</u> Year <u>19 60</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7th July 1883</u>	9. AGE (In years last birthday) <u>77</u> yrs.	10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		11. IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Packer (ret.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Keystone Elec Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Leonard Joynes</u>				14. MOTHER'S MAIDEN NAME <u>Ide (Unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>212 03 3912</u>		17. INFORMANT <u>Mrs. Ada B. Joynes</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Haemorrhage</u> 331X DUE TO <u>Arterio-sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ca of prostate + bladder</u> DUE TO (c) <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days - 10-12 hrs</u> <u>3-4 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>5/18/60</u> , to <u>8/18</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8/18/60</u> , 19 <u>60</u> , and that death occurred at <u>5:15 P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Chas. E. Ball Jr.</u> M.D. <u>Linthicum Md.</u>				ADDRESS (Street, city or town, state) <u></u> DATE SIGNED <u>8/19/60</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>20th Aug. '60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. S. Smith</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>Aug 22 '60</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			





08758

CERTIFICATE OF DEATH

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1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Pasadena</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		d. STREET ADDRESS <b>2nd St. Long Point</b>	
3. NAME OF DECEASED (Type or print) First <b>Isabel</b> Middle <b>KIRBY</b> Last <b>KIRBY</b>		4. DATE OF DEATH Month <b>August</b> Day <b>31</b> Year <b>1960</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 26, 1909</b>
9. AGE (In years last birthday) <b>51</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk (ret.)</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Dep't. Store</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>Harry S. Warthen</b>	
14. MOTHER'S MAIDEN NAME <b>Anna M. Sheeler</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. <b>214 24 6979</b>		17. INFORMANT <b>Mr. James E. Kirby</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular nephrosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Diabetes mellitus</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs.</b> <b>10 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF DEATH Hour _____ o. m. _____ p. m. _____ Month _____ Day _____ Year _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that (I) <b>physician</b> attended the deceased from <b>July</b> 19 <b>58</b> to <b>August</b> 19 <b>60</b> , that (I) <b>yes</b> saw the deceased alive on <b>August 30</b> 19 <b>60</b> , and that death occurred at _____ M, from the causes and on the date stated above.			
22a. SIGNATURE <b>John L. Hedeman</b>		22b. DATE SIGNED <b>9/1/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>John L. Hedeman</b>		22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>3rd Sept. 1960</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Glen Haven Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Glen Burnie, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Richard V. Singleton</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 6 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>			

08787

CERTIFICATE OF DEATH

8717

John A. Smith      Anna A. Smith      John A. Smith      Anna A. Smith  
Age 45      Age 45      Age 45      Age 45  
Cause of Death      Cause of Death      Cause of Death      Cause of Death

X      John A. Smith      Anna A. Smith      John A. Smith      Anna A. Smith

CA      John A. Smith      Anna A. Smith      John A. Smith      Anna A. Smith

CA      John A. Smith      Anna A. Smith      John A. Smith      Anna A. Smith

7.7      John A. Smith      Anna A. Smith      John A. Smith      Anna A. Smith

CA      John A. Smith      Anna A. Smith      John A. Smith      Anna A. Smith

CA      John A. Smith      Anna A. Smith      John A. Smith      Anna A. Smith

CA      John A. Smith      Anna A. Smith      John A. Smith      Anna A. Smith

CA      John A. Smith      Anna A. Smith      John A. Smith      Anna A. Smith

CA      John A. Smith      Anna A. Smith      John A. Smith      Anna A. Smith

CA      John A. Smith      Anna A. Smith      John A. Smith      Anna A. Smith

CA      John A. Smith      Anna A. Smith      John A. Smith      Anna A. Smith

CA      John A. Smith      Anna A. Smith      John A. Smith      Anna A. Smith

CA      John A. Smith      Anna A. Smith      John A. Smith      Anna A. Smith

CA      John A. Smith      Anna A. Smith      John A. Smith      Anna A. Smith

CA      John A. Smith      Anna A. Smith      John A. Smith      Anna A. Smith

CA      John A. Smith      Anna A. Smith      John A. Smith      Anna A. Smith



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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8765  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08726

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>400 Ritchie Highway</u>				d. STREET ADDRESS <u>1 Same</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Emilie Elsa Breckel Krutzfeldt</u> First Middle Last				4. DATE OF DEATH Month <u>August</u> Day <u>16th</u> Year <u>19 60</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/24/06</u>	
9. AGE (In years lost birthday) <u>54</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Germany</u>	
13. FATHER'S NAME <u>William Breckel</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Mueller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Ernest Krutzfeldt (husband)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of left ovary</u> DUE TO <u>175.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>175.0</u> DUE TO (c) <u>175.0</u>				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>8/7/60</u> 19 <u>60</u> to <u>8/16/60</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>8/15/60</u> 19 <u>60</u> , and that death occurred at <u>1:30 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Gustave H. Faubert</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/16/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				22d. ADDRESS <u>Glen Burnie, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug. 19, 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial</u>		23d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley</u>				ADDRESS <u>Glen Burnie, Md</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 19 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>							

08738

CERTIFICATE OF DEATH

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8766  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel Co.</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>A.A.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Fairhaven</b>				c. LENGTH OF STAY IN 1b <b>25 Yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <b>Fairhaven Manor</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Francis Joseph Little</b>				4. DATE OF DEATH Month Day Year <b>August 13, 19 60</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 10, 1896</b>	9. AGE (In years last birthday) <b>64</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Executive</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>C. &amp; P. Tele. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Harry Little</b>				14. MOTHER'S MAIDEN NAME <b>Katherine Sullivan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Elizabeth Owings Little Fairhaven Manor Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Pancreas</b> <b>157X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <b>8 Months</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>December 19, 59</b> , to <b>8/13/60</b> , 19____, that I last saw the deceased alive on <b>8/12/60</b> , 19____, and that death occurred at <b>11:40 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Medical Arts Bldg., Baltimore, Md.</b> DATE SIGNED <b>8/13/60</b>							
ACTUAL SIGNATURE <b>John Russell Davis</b>		M.D. <b>John Russell Davis, M.D.</b>					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/16/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Our Lady of Sorrows Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Owensville, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ritchie Bros. Fun'l Homw-Marlboro, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 23 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton S. Frank</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. This certificate is for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 3 should be detached for use as the burial-transit permit.

CERTIFICATE OF DEATH

2506

1. NAME OF DECEASED FRANCIS JOHN H.		2. SEX Male		3. AGE 45		4. DATE OF BIRTH 1910		5. PLACE OF BIRTH BALTIMORE, MARYLAND	
6. OCCUPATION Carpenter		7. MARITAL STATUS Married		8. DATE OF MARRIAGE 1935		9. PLACE OF MARRIAGE BALTIMORE, MARYLAND		10. NAME OF SPOUSE JANE M. H.	
11. DATE OF DEATH 1955		12. TIME OF DEATH 10:00 AM		13. PLACE OF DEATH Home		14. CAUSE OF DEATH Heart Disease		15. MANNER OF DEATH Natural	
16. SIGNATURE OF PHYSICIAN J. H. Smith		17. SIGNATURE OF WITNESSES J. H. Smith, J. H. Smith		18. SIGNATURE OF DECEASED Francis John H.		19. SIGNATURE OF SPOUSE Jane M. H.		20. SIGNATURE OF NEAREST RELATIVE John H. H.	
21. SIGNATURE OF REGISTRAR J. H. Smith		22. SIGNATURE OF CLERK J. H. Smith		23. SIGNATURE OF JURY J. H. Smith, J. H. Smith		24. SIGNATURE OF JUDGE J. H. Smith		25. SIGNATURE OF SHERIFF J. H. Smith	

RECEIVED  
BALTIMORE, MARYLAND  
JAN 1 1956

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8767

## CERTIFICATE OF DEATH

08728

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville</u>				c. LENGTH OF STAY IN 1b <u>17</u> <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Knollingswood Nursing Home</u>				d. STREET ADDRESS <u>131 Bloomsbury Sq.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CARRIE LOWMAN</u>				4. DATE OF DEATH Month <u>AUGUST</u> Day <u>10</u> Year <u>1960</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 8, 1883</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>10</u> Hours <u>19</u> Min.		11. IF UNDER 24 HRS. Hours <u>19</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Odenton, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Joshua Meek</u>				14. MOTHER'S MAIDEN NAME <u>Martha (unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>husband's 214 05 0201</u>		INFORMANT Address <u>Frank Thomas Lowman Sr. husband- same as # 2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral artery thrombosis</u> <u>332</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>August 8/9</u> , 19 <u>58</u> , to <u>8/10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8/9</u> , 19 <u>60</u> , and that death occurred at <u>4:20 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <u>Richard N. Peeler</u> M.D. PHYSICIAN'S NAME (Type) <u>Richard N. Peeler MD</u> <u>121 Cathedral Street, Annapolis, Maryland</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 13, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hillcrest Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u> ADDRESS <u>Annapolis, Maryland</u>				24a. REC'D BY REGISTRAR <u>AUG 15 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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8768

## CERTIFICATE OF DEATH

08729

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>				c. LENGTH OF STAY IN 1b <b>1 mo. 1 year 11 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>			
				d. STREET ADDRESS <b>722 Charles Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Alice</b> Middle Last <b>McDonald</b>				4. DATE OF DEATH Month <b>8</b> Day <b>28</b> Year <b>60</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 20, 1932</b>	
				9. AGE (In years last birthday) <b>28</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>			
				11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>			
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Diana Daugherty</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>	
				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>491X</b> IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Schizophrenic Reaction, Paranoid Type</b>							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>----- 19</b>				20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>	
				20f. (City or town) <b>-----</b>		(County) (State)	
21. I certify that I attended the deceased from <b>3/6</b> , 19 <b>59</b> , to <b>8/28</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>8/28</b> , 19 <b>60</b> , and that death occurred at <b>4:45A.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>8/29/60</b>							
ACTUAL SIGNATURE <b>L. Benedict, M. D.</b>				M.D. <b>Crownsville State Hospital, Md. 8/29/60</b>			
PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>				<b>Crownsville State Hospital, Md. 8/29/60</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>9-1-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MOUNT AUBURN</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>ISAIAH L. BROWN</b>				ADDRESS <b>108 W. MONTGOMERY ST.</b>		24a. REC'D BY REGISTRAR <b>Aug 31 '60</b>	
				24b. REGISTRAR'S SIGNATURE <b>Charles E. Hines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

PS50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

8718

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08730

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>10</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>G.</b> Last <b>MEREDITH</b>				4. DATE OF DEATH Month <b>August</b> Day <b>3</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>February 3, 1887</b>	
9. AGE (In years last birthday) <b>73</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret- Lumber Dealer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lumber</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>William L. Meredith</b>		14. MOTHER'S MAIDEN NAME <b>Virginia Anderson</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>153-8</b>		17. INFORMANT <b>Mrs Iris Knight Meredith</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of colon with widespread metastases</b> DUE TO (b) <b>metastases</b> DUE TO (c) <b>lying cause last.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 21, 1960</b> , to <b>Aug. 3, 1960</b> , that (I) <b>yes</b> last saw the deceased alive on <b>Aug. 3, 1960</b> , and that death occurred at <b>12:58 P.M.</b> M, from the causes and on the date stated above.							
22a. SIGNATURE <b>Richard N. Peeler</b>		22b. DATE <b>8/3/60</b>		22c. PHYSICIAN'S NAME (Type) <b>Richard N. Peeler</b>		22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug 7-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Salem Church Cemt</b>		23d. LOCATION (City, town, or county) (State) <b>Gloucester Va</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Taylor Sons</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 8 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Christina S. Kneale</b>			

08750

CERTIFICATE OF DEATH

8718

Name of Deceased		Age		Sex		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Signature of Physician		Signature of Registrar	
John Doe		45		Male		White		1930-01-01		1975-03-15		New York, NY		Heart Disease		[Signature]		[Signature]	
Name of Informant		Relationship		Occupation		Address		City		State		Zip		Date of Report		Signature of Informant		Signature of Registrar	
Jane Doe		Wife		Homemaker		123 Main St		New York		NY		10001		1975-03-20		[Signature]		[Signature]	
Name of Burial Place		Date of Burial		Time of Burial		Name of Minister		Name of Church		City		State		Zip		Signature of Minister		Signature of Registrar	
St. John's Church		1975-03-22		10:00 AM		Rev. John Smith		St. John's Church		New York		NY		10001		[Signature]		[Signature]	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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063  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
8719  
CERTIFICATE OF DEATH

08731

1. PLACE OF DEATH o. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b <b>3 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Pasadena</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>WESLEY</b> Last <b>MITCHELL</b>				4. DATE OF DEATH Month <b>August</b> Day <b>30</b> Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>October 31, 1903</b>	
9. AGE (In years last birthday) <b>56</b> yrs.		IF UNDER 1 YEAR Months <b>56</b> Days <b>56</b> Hours <b>56</b> Min. <b>56</b>		IF UNDER 24 HRS. Months <b>56</b> Days <b>56</b> Hours <b>56</b> Min. <b>56</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TRACK MAINTENANCE</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>BTL R. R. Co</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>							
13. FATHER'S NAME <b>JOHN MITCHELL</b>				14. MOTHER'S MAIDEN NAME <b>IDA PALMER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>MRS EDNA E. MULLIKIN</b> Address <b>9100 48th Pl. College Park, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary embolism?</b> 410X DUE TO <b>Rheumatic Heart Disease</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. <b>mitral stenosis &amp; insufficiency</b> DUE TO <b>30 yrs</b>				INTERVAL BETWEEN ONSET AND DEATH <b>12 hr.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, <b>19</b> Day, <b>19</b> Year, <b>19</b> Hour o. m. <b>19</b> p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) <b>7 - C - 60</b>				20g. (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>7 - C - 60</b> , to <b>8 - 30 - 1960</b> , that (I) (we) last saw the deceased alive on <b>8 - 29 - 1960</b> , and that death occurred at <b>6 AM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Frank M Shipley</b>				22b. DATE <b>8 - 30 - 60</b>		22c. PHYSICIAN'S NAME (Type) <b>Frank M Shipley</b>	
22d. ADDRESS <b>Annapolis, Md</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>9-2-1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>	
23d. LOCATION (City, town, or county) (State) <b>Bladensburg, Md</b>							
24. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers, Co. Riverdale, Md</b>				25a. REC'D BY REGISTRAR <b>SEP 2 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur J. Hines</b>	

08751

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE  
WASHINGTON, D. C.

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [illegible]

RE: [illegible]

DATE: [illegible]

TIME: [illegible]

TO: SAC, NEW YORK

RE: [illegible]

DATE: [illegible]

TIME: [illegible]

FROM: [illegible]

TO: [illegible]

RE: [illegible]

DATE: [illegible]

TIME: [illegible]

FROM: [illegible]

SUBJECT: [illegible]

TO: SAC, NEW YORK

RE: [illegible]

DATE: [illegible]

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [illegible]

DATE: [illegible]

RE: [illegible]

DATE: [illegible]

TIME: [illegible]

FROM: [illegible]

TO: [illegible]

SUBJECT: [illegible]

RE: [illegible]

DATE: [illegible]

TIME: [illegible]



## CERTIFICATE OF DEATH

Reg. Dist. No.

08732

8769

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>1</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>				d. STREET ADDRESS <u>3048 Ascension Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>MOZELLA MONTGOMERY</u>				4. DATE OF DEATH Month <u>8</u> Day <u>5</u> Year <u>1960</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/22/12</u>	
9. AGE (In years, last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Kitchen Helper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>USA</u>			
11. BIRTHPLACE (State or foreign country) <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Willie Carolina</u>				14. MOTHER'S MAIDEN NAME <u>Lulla Carolina</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>unknown</u>			
17. INFORMANT <u>Hospital Records</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyperglycemia + Uremia</u> <u>260X</u> DUE TO <u>Diabetes Mellitus</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes Mellitus</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Glioma</u>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6/24</u> , 19 <u>60</u> to <u>8/5</u> , 19 <u>60</u> that I last saw the deceased alive on <u>8/5</u> at <u>8:05 P.M.</u> and that death occurred at <u>8:05 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville State Hospital</u> DATE SIGNED <u>August 8, 1960</u>							
ACTUAL SIGNATURE <u>Lucy M. Henry Mapp M.D.</u> M.D.				PHYSICIAN'S NAME (Type) <u>Crownsville Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-10-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem</u>		22d. LOCATION (City, town, or county) (State) <u>Anne Arundel Co</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Elroy O. Wilson</u> ADDRESS <u>1000 Brantley Ave.</u>				24a. REC'D BY REGISTRAR <u>Aug 8 1960</u>		24b. REGISTRAR'S SIGNATURE <u>Orlando L. Kinn</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8878

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

<p>1. NAME OF DECEASED          JAMES H. HARRIS</p>		<p>2. PLACE OF DEATH          HOME</p>	
<p>3. DATE OF DEATH          JAN 10 1900</p>		<p>4. TIME OF DEATH          10:00 AM</p>	
<p>5. PLACE OF BIRTH          BALTIMORE, MD</p>		<p>6. AGE          45</p>	
<p>7. SEX          MALE</p>		<p>8. OCCUPATION          LABORER</p>	
<p>9. CAUSE OF DEATH          HEART DISEASE</p>		<p>10. MANNER OF DEATH          NATURAL</p>	
<p>11. SIGNATURE OF PHYSICIAN          J. H. HARRIS</p>		<p>12. SIGNATURE OF WITNESSES          J. H. HARRIS</p>	
<p>13. SIGNATURE OF REGISTRAR          J. H. HARRIS</p>		<p>14. SIGNATURE OF CLERK          J. H. HARRIS</p>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH. IT IS NOT VALID FOR ANY OTHER PURPOSES. IT IS NOT VALID FOR ANY OTHER PURPOSES. IT IS NOT VALID FOR ANY OTHER PURPOSES.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. For page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
8720 CERTIFICATE OF DEATH 08733

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>Gambrills</u>	
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>W.</u> Last <u>Moravec SR</u>		4. DATE OF DEATH Month <u>August</u> Day <u>16</u> Year <u>19 60</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-4-1884</u>
9. AGE (In years last birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months <u>7</u> Days <u>15</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dairyman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S.N. Dairy</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-32-6929</u>	
17. INFORMANT <u>Records at U.S. Navy</u>		Address <u>Baltimore Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Men with cerebral hemorrhage</u> <u>290.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Thrombocytopenic purpura</u> DUE TO (c) <u>severe anemia (hypochromic)</u>		INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Gastro-intestinal fistula -</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <u>Jan</u> Day <u>15</u> Year <u>19 55</u> Hour <u>o. m.</u> p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 15, 1955</u> to <u>Aug 16, 1960</u> , that (I) (we) last saw the deceased alive on <u>8/16</u> 19 <u>60</u> , and that death occurred at <u>6:00</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>S. Borzuck</u>		22b. DATE SIGNED <u>Aug 16 1960</u>	
22c. PHYSICIAN'S NAME (Type) <u>S. Borzuck</u>		22d. ADDRESS <u>Amos Garrett Bldg. 1st Annapolis Md</u>	
23a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug 18-1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Baldwin Memorial</u>		23d. LOCATION (City, town, or county) (State) <u>Millersville Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 18 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles S. Knaus</u>			

88028

CERTIFICATE OF DEATH

88028

NAME OF DECEASED: [illegible] SEX: [illegible] AGE: [illegible]

RESIDENCE: [illegible]

DATE OF DEATH: 11-1-1914

PLACE OF DEATH: [illegible]

Cause of Death: [illegible]

Signature of Physician: [illegible]

Signature of Registrar: [illegible]

Signature of Coroner: [illegible]

Signature of Medical Examiner: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

Signature of [illegible]: [illegible]

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8770

## CERTIFICATE OF DEATH

Reg. Dist. No. 08734

1. PLACE OF DEATH o. COUNTY <b>MARYLAND</b> <b>Anne Arundel</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Dor</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>3 mo. 6 yrs. 15 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Vienna</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>				d. STREET ADDRESS <b>Underwood R.F.D.</b>			
3. NAME OF DECEASED (Type or print) First <b>Talbot</b> Middle <b>Morris</b> Last <b>Morris</b>				4. DATE OF DEATH Month <b>8</b> Day <b>11</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1910</b> <b>March 17, 1910</b>		9. AGE (In years last birthday) <b>50 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farming and Factory Work</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland (Dorchester Co.)</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James Morris</b>				14. MOTHER'S MAIDEN NAME <b>Jane ?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>522X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4/26</b> , <b>1954</b> , to <b>8/11</b> , <b>1960</b> that I last saw the deceased alive on <b>8/11</b> , <b>1960</b> , and that death occurred at <b>9:00 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Crownsville State Hospital, Md. 8/12/60</b>							
ACTUAL SIGNATURE <b>Lionel McHenry Mapp</b>		M.D. <b>Crownsville State Hospital, Md. 8/12/60</b>					
PHYSICIAN'S NAME (Type) <b>Lionel McHenry Mapp, M. D.</b>		M.D. <b>Crownsville State Hospital, Md. 8/12/60</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8-15-60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Vienna Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Vienna, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. Hampton Don Federalburg Md.</b>				24a. REC'D BY REGISTRAR DATE <b>AUG 16 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>	



08530



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 10a, telephone call, Wm. J. Tickner & Sons 8/29/1960

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>ALLEGANY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hgts.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ALLEGANY</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>205 W. Greenwood</u>		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Cooke Morton</u>		4. DATE OF DEATH Month Day Year <u>Aug 27 1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 19 '55</u>
9. AGE (In years, last birthday) <u>42 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supt. - P.M.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Motor Vehicles - Wash., D.C.</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington, DC</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James C. Morton</u>		14. MOTHER'S MAIDEN NAME <u>Emma Bell Dobbin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Emma Morton</u>		Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-Vascular Disease</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic</u> DUE TO (c) <u>Heart</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 yrs.</u> <u>5-8 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8/27/60</u> , 19 <u>49</u> , to <u>8/27</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8/27/60</u> , 19 <u>  </u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Chas. L. Ball</u> M.D.		DATE SIGNED <u>8/27/60</u>	
PHYSICIAN'S NAME (Type) <u>Chas. L. Ball</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>8/30/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Mount Crem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tickner &amp; Sons - Balto.</u>		24a. REC'D BY REGISTRAR <u>17</u>	
24b. REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

Item 20 Film 26 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
8-26-60 ams

8721

# CERTIFICATE OF DEATH

08736

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ANNE ARUNDEL</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>		c. LENGTH OF STAY IN 1b <b>10</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ANNE ARUNDEL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANDREW</b> Middle <b>J</b> Last <b>MUSTERMAN</b>		4. DATE OF DEATH Month <b>AUGUST</b> Day <b>13</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 24, 1900</b>
9. AGE (In years lost birthday) <b>59 yrs.</b>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gan and Elect Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Annapolis, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Andrew H. Musterman</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Smith</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>212 05 6388</b>	
17. INFORMANT <b>Mrs Estelle F. Musterman- Wife- same as # 2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Poisoning - Liver Failure</b> <b>971.8</b> DUE TO <b>Ingestion of Insecticide (self inserted)</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>2 days</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>SUICIDE</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>ANNAPOLIS</b>		20f. (City or town) (County) (State) <b>AA MD</b>	
21. I certify that I attended the deceased from <b>8-10-60, 19 60</b> , to <b>8-13-1960</b> , that I last saw the deceased alive on <b>8-13-19 60</b> , and that death occurred at <b>4 45</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>5 Shaw Street, Annapolis, Maryland</b> DATE SIGNED <b>8-15-60</b>			
ACTUAL SIGNATURE <b>James R. Martin</b> M.D.		PHYSICIAN'S NAME (Type) <b>James R. Martin MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Aug. 16, 1960</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>		ADDRESS <b>Annapolis, Maryland</b>	
24a. REC'D BY REGISTRAR <b>AUG 18 '60</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

03336

CERTIFICATE OF DEATH



DEATH

J

X

State of New York

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: All of this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
ISM 9/59

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8772  
Item 7 8316270 9-6-60 et

1  
M  
X

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08737

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena, Md.</u> c. LENGTH OF STAY IN lb <u>22 yrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GAYFIELD'S FARM, Mt. Rd. Pasadena</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA County</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Pasadena, Md.</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Joseph O'Meara</u> First Middle Last 4. DATE OF DEATH <u>Aug. 29</u> 1960 Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>Cau</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>Dec. 9, 1889</u> 9. AGE (In years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractor</u> 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>ANNA R. PHANN</u>		13. FATHER'S NAME <u>James J. O'Meara</u> 14. MOTHER'S MAIDEN NAME <u>Mary Teresa Flannigan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>Son</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>Coronary Arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <u>June</u> 1960 to <u>Aug</u> 1960, that (I) (we) last saw the deceased alive on <u>Aug</u> 1960 and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above. 22a. SIGNATURE <u>Richard C. Reba</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) <u>Richard C. Reba</u> 22d. ADDRESS <u>4714 Greenspring Ave. Balt.</u> 22b. DATE SIGNED	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Aug. 30, 1960</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Cathedral</u> 23d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>277 Meade Ave 805 D Calvert H</u> 25a. REC'D BY REGISTRAR <u>SEP 1 '60</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

108731

EXHIBIT C

108731



108731



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 6269 8-19-60 et

8773

## CERTIFICATE OF DEATH

Reg. Dist. No.

08738

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Drury</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Drury</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Edward</b> First <b>Owens</b> Middle Last				4. DATE OF DEATH <b>August 14</b> Month Day Year <b>1960</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7/28/1876</b> 1877	
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <b>Wilson Owens</b>				14. MOTHER'S MAIDEN NAME <b>Matilda Langford</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Matilda Riggs- Drury, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Cardio Vascular Renal</b> DUE TO <b>Nausea</b> (c) <b>10 yrs.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Immed</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Mar 50</b> , 19 <b>50</b> , to <b>Aug 14</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>1 Aug</b> , 19 <b>60</b> , and that death occurred at <b>12:30 P.</b> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Upper Marlboro</b> DATE SIGNED <b>14 Aug 60</b>							
ACTUAL SIGNATURE <b>R. B. Danner</b> M.D.				PHYSICIAN'S NAME (Type) <b>Arthur S. Hines</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>8/18/60</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Moses Cemetery</b>				22d. LOCATION (City, town, or county) (State) <b>Anne Arundel Co, Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>John V. Johnson</b> ADDRESS <b>30 H Street, N.E.</b>				24a. REC'D BY REGISTRAR <b>AUG 16 60</b> DATE 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00338

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Signature of informant		12. Signature of witness	
13. Signature of funeral director		14. Signature of undertaker		15. Signature of cemetery	
16. Signature of health officer		17. Signature of coroner		18. Signature of jury	
19. Signature of jury		20. Signature of jury		21. Signature of jury	
22. Signature of jury		23. Signature of jury		24. Signature of jury	
25. Signature of jury		26. Signature of jury		27. Signature of jury	
28. Signature of jury		29. Signature of jury		30. Signature of jury	
31. Signature of jury		32. Signature of jury		33. Signature of jury	
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49. Signature of jury		50. Signature of jury		51. Signature of jury	
52. Signature of jury		53. Signature of jury		54. Signature of jury	
55. Signature of jury		56. Signature of jury		57. Signature of jury	
58. Signature of jury		59. Signature of jury		60. Signature of jury	
61. Signature of jury		62. Signature of jury		63. Signature of jury	
64. Signature of jury		65. Signature of jury		66. Signature of jury	
67. Signature of jury		68. Signature of jury		69. Signature of jury	
70. Signature of jury		71. Signature of jury		72. Signature of jury	
73. Signature of jury		74. Signature of jury		75. Signature of jury	
76. Signature of jury		77. Signature of jury		78. Signature of jury	
79. Signature of jury		80. Signature of jury		81. Signature of jury	
82. Signature of jury		83. Signature of jury		84. Signature of jury	
85. Signature of jury		86. Signature of jury		87. Signature of jury	
88. Signature of jury		89. Signature of jury		90. Signature of jury	
91. Signature of jury		92. Signature of jury		93. Signature of jury	
94. Signature of jury		95. Signature of jury		96. Signature of jury	
97. Signature of jury		98. Signature of jury		99. Signature of jury	
100. Signature of jury		101. Signature of jury		102. Signature of jury	



Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

8722

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08739

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>307 North Glen Avenue</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Grace</b> Middle <b>D.</b> Last <b>Owings</b>		4. DATE OF DEATH Month <b>August</b> Day <b>30</b> Year <b>19 60</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 1, 1878</b>	9. AGE (In years last birthday) <b>82</b> yrs.	IF UNDER 1 YEAR Months <b>82</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Dawson</b>			14. MOTHER'S MAIDEN NAME <b>Margaret Simmons</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Hospital Records</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>422.1</b> IMMEDIATE CAUSE (a) <b>Central Thrombosis</b> DUE TO <b>Anticoagulation C. V. Medication</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>Quico.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 20, 1960</b> to <b>Aug 30, 1960</b> that (I) (we) last saw the deceased alive on <b>Aug 30, 1960</b> and that death occurred at <b>1:14 PM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Maurice Klawans</b>		M.D. <input checked="" type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Aug 30, 1960</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Maurice Klawans</b>		22d. ADDRESS <b>Southgate Ave., Annapolis, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept 2, 1960</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodfields Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Galesville, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Hopping Funeral Home</b>		ADDRESS <b>Annapolis, Maryland</b>		25a. REC'D BY REGISTRAR <b>SEP 1 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

02730

STATE OF DEATH

1925

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1

Form with multiple sections and fields, mostly illegible due to fading and bleed-through. Visible text includes:

- NAME OF DECEASED
- AGE
- SEX
- DATE OF DEATH
- PLACE OF DEATH
- CAUSE OF DEATH
- SIGNATURE OF PHYSICIAN
- SIGNATURE OF WITNESSES
- DATE OF ENTRY

Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
TO FUNERAL DIRECTOR: If this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
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DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
08740

1. PLACE OF DEATH o. COUNTY <u>HUNNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>H.A. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FERRY FARMS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> 10	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Old Annapolis Blvd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Sabra</u> Middle <u>C.</u> Last <u>Pate</u>		4. DATE OF DEATH Month <u>8</u> Day <u>3</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7-17-1878</u>
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u>8</u> Days <u>3</u> Hours <u>19</u> Min.	11. IF UNDER 24 HRS. Months <u>8</u> Days <u>3</u> Hours <u>19</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	
11. BIRTHPLACE (State or foreign country) <u>Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CLEMENT</u>		14. MOTHER'S MAIDEN NAME <u>MEADOR</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>William A. Pate</u> Address <u>#2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Insufficiency</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u> <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Colon</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-1-1960</u> to <u>8-3-1960</u> , that (I) (we) last saw the deceased alive on <u>8-2-1960</u> , and that death occurred at <u>4:15 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>James R. Martin</u>		22b. DATE SIGNED <u>8/3/60</u>	
22c. PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>		22d. ADDRESS <u>ANNAPOLIS, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>8-7-1960</u>		23b. DATE THEREOF <u>8-7-1960</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fordsville Cemetery</u>		23d. LOCATION (City, town, or county) (State) <u>FORDSVILLE Ky.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u> ADDRESS <u>Sus Annapolis, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 8 '60</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Travis</u>			

02540

CERTIFICATE OF DEATH

8174

John J. Brown

1914

John J. Brown

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John J. Brown

1914

John J. Brown

John J. Brown

John J. Brown

John J. Brown

John J. Brown

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John J. Brown

John J. Brown

John J. Brown

John J. Brown

John J. Brown



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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FOR STATE  
HEALTH DEPT.  
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VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8723

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08741

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>D. A. Co.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>D. A. Co.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Deep Creek - Annapolis</u>		c. LENGTH OF STAY IN 1b <u>Lake Shore - Maryland.</u>		X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. - Anne Arundel General.</u>			d. STREET ADDRESS <u>Rt. 7, Box 218 (Pasadena, Maryland)</u>		e. IS RESIDENCE ON A FARM? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Clayton</u> Last <u>Powell</u>			4. DATE OF DEATH Month <u>8</u> Day <u>14</u> Year <u>1960</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-17-09</u>	9. AGE (In years last birthday) <u>51</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Balto. City Schools</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>
13. FATHER'S NAME <u>John W. Powell</u>			14. MOTHER'S MAIDEN NAME <u>Alice V. Cunningham</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		
17. INFORMANT <u>George C. Powell, Jr.,</u>			Address <u>Severna Park, Md</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac disease</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8-14-60.</u>	
EXAMINER'S NAME (Type) <u>E. Linhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>8-17-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Cemetery</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook, Inc., 1217 St. Paul Street</u>		ADDRESS <u>Elkridge, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 17 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>					



A15 (4)  
A 9/59

08742

1. PLACE OF DEATH a. COUNTY <u>aa</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u>		b. COUNTY <u>aa</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>207 Wardour Drive</u>				d. STREET ADDRESS <u>1207 Wardour Drive</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Alexander</u> Middle <u>S.</u> Last <u>Proskey</u>		4. DATE OF DEATH Month <u>Aug</u> Day <u>26</u> Year <u>1960</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-26-1884</u>		9. AGE (In years last birthday) <u>76</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ref. Postmaster</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Government</u>		11. BIRTHPLACE (State or foreign country) <u>New York City</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Samuel Proskey</u>		14. MOTHER'S MAIDEN NAME <u>Minnie Cobb</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mary M. Proskey</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PULMONARY EDEMA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>1 Hour</u> <u>10 YRS.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>APRIL 1957</u> to <u>23 AUG 1960</u> , that (I) (we) last saw the deceased alive on <u>23 AUG 1960</u> , and that death occurred <u>23 AUG</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>Edward S. Beck MD</u>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Aug 28-1960</u>		<u>St Margarets Comt</u>		<u>St Margarets Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Kelly Sons</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 30 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneiss</u>	

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

8735 MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Anne Arundel				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) b. STATE Maryland c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Millersville			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Severna Park				c. LENGTH OF STAY IN 2 hrs.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Severn River				d. STREET ADDRESS S. Crain Highway			
3. NAME OF DECEASED (Type or print) Earl James Pumphrey				4. DATE OF DEATH August 5th. 19 60			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/29/96	
9. AGE (In years last birthday) 64 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer (ret.)				10b. KIND OF BUSINESS OR INDUSTRY Farmer for self			
11. BIRTHPLACE (State or foreign country) Millersville, Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Walter Pumphrey				14. MOTHER'S MAIDEN NAME Susanna Wade			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes 1918 W.W.I				16. SOCIAL SECURITY NO. 218-363686			
17. INFORMANT Mrs. Josephine Pumphrey (wife)				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)							INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Gustave H. Faubert, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 8/6/60			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 8 August 1960		22c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.	
23. FUNERAL DIRECTOR R. Singleton				24a. REC'D BY REGISTRAR DATE AUG 11 '60		24b. REGISTRAR'S SIGNATURE G. B. Bunn	
22d. LOCATION (City, town, or country) (State) Glen Burnie, Md.							

1980

DEATH CERTIFICATE

1980





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 08744									
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lothian</u>			c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lothian</u>			d. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) ---					d. STREET ADDRESS ---				
3. NAME OF DECEASED (Type or print) <u>Edward</u> First <u>Hugh</u> Middle <u>Hugh</u> Last <u>Rawlings</u>					4. DATE OF DEATH Month <u>8</u> Day <u>2</u> Year <u>1960</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 14, 1915</u> (44) yrs.		9. AGE (In years last birthday) Months <u>12</u> Days <u>12</u> Hours <u>12</u> Min. <u>12</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Farming</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Unknown</u>					14. MOTHER'S MAIDEN NAME <u>Anna A. Shepherd</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u> (If yes, give war or dates of service) ---				16. SOCIAL SECURITY NO. ---		17. INFORMANT Address <u>Ashby Shepherd- Lothian, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Neck</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Multiple Contusions</u> (c) <u>Probable Fractured Skull</u> DUE TO cause lost.									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Tractor overturned, pinned him under</u>					
20c. TIME OF INJURY Hour <u>o. m.</u> <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>farm</u>		20f. (City or town) <u>Lothian</u>		(County) <u>AA</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Emily H. Wislon</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>Emily H. Wislon, M.D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					DATE SIGNED <u>8/2/60</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/4/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Zion Cemetery</u>			22d. LOCATION (City, town, or county) (State) <u>Lothian Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ritchie Bros. Fun'l Home-Marlboro, Md.</u>					24a. REC'D BY REGISTRAR DATE <u>AUG 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>		

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

877

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HARRIS		45		M		W		JAN 15 1918		BALTIMORE, MD.	
RESIDENCE		OCCUPATION		EDUCATION		MARRIAGE		CAUSE OF DEATH		MANNER OF DEATH	
1212 N. 10th St.		Carpenter		High School		Married		Heart Disease		Natural	
PREVIOUS ILLNESS		SYMPTOMS		DIAGNOSIS		TREATMENT		PROGNOSES		FINDINGS	
None		Chest pain, shortness of breath		Myocardial Infarction		Medicine		Favorable		Coronary artery disease, thrombosis	
DATE OF EXAMINATION		TIME OF EXAMINATION		PLACE OF EXAMINATION		SIGNATURE OF EXAMINER		TITLE OF EXAMINER		STAMP	
JAN 16 1918		10:30 AM		At Home		J. H. HARRIS		Physician		BALTIMORE, MD.	

RECEIVED JAN 16 1918

MISSOURI STATE DEPARTMENT OF HEALTH - BALTIMORE 18

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 9/59

Item 18 Film 269 8-19-60											
MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND											
8776 CERTIFICATE OF DEATH 08745											
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ft Geo G. Meade</u>					c. LENGTH OF STAY IN lb <u>Since 30 June 60</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park</u>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>					d. STREET ADDRESS <u>1 Rt # 2 Box 234</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Torrence</u> Middle <u>W.</u> Last <u>Reeder</u>					4. DATE OF DEATH Month <u>August</u> Day <u>2</u> Year <u>19 60</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Cau</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> <u>N/A</u> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>30 June 1960</u>		9. AGE (In years lost birthday) yrs. <u>1</u> Months <u>2</u> Days <u>2</u> Hours <u>Min.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N/A</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>N/A</u>			11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Thomas L Reeder</u>					14. MOTHER'S MAIDEN NAME <u>Mary Wilhem</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>			16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT (Father) <u>Box 234 Rt # 2 Severna Pk, Maryland</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>692.4</u> DUE TO <u>Sepsis</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. } DUE TO <u>Abscess of leg &amp; furuncle of arm.</u> (b) } (c) }										INTERVAL BETWEEN ONSET AND DEATH <u>Less than 24 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from <u>28 July 19 60</u> to <u>2 August 19 60</u> , that (I) (we) lost saw the deceased alive on <u>2 Aug 1960</u> , and that death occurred at <u>5:25 PM</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>W. H. Miller Jr.</u>					M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>3 Aug 60</u>				
22c. PHYSICIAN'S NAME (Type) <u>WILBUR H. MILLER, Capt., M.C.</u>					22d. ADDRESS <u>USA Hosp Ft Geo G. Meade, Maryland</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>6 Aug. 1960</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Baldwins Memorial Ch, Cem</u>			23d. LOCATION (City, town, or county) (State) <u>Millersville, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Singleton Funeral Home - Robert P. Ware</u>					ADDRESS <u>Ben Burnie</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 12 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>		

2063211XUG

08782

CERTIFICATE OF DEATH

1918

1

CHIEF CLERK

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08746

Reg. Dist. No.

8777

<b>1. PLACE OF DEATH</b> a. COUNTY <u>A. A. Co</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St Margarets RFD Annapolis</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>2004</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore - Maryland</u> d. STREET ADDRESS <u>2442 N. Calvert</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>VIRGINIA S Ridley</u>				<b>4. DATE OF DEATH</b> Month <u>8</u> Day <u>16</u> Year <u>1960</u>											
<b>5. SEX</b> <u>Female</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>Aug. 15, 1910</u>		<b>9. AGE</b> (In years last birthday) <u>50 yrs.</u>		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House wife</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>own home</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Norfolk, Va.</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>			
<b>13. FATHER'S NAME</b> <u>Charles A. Saunders</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Tinnie Cook</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>no</u>				<b>16. SOCIAL SECURITY NO.</b> <u>305 34 0106</u>				<b>17. INFORMANT</b> <u>Thomas P. Ridley Jr. - Box 23 RFD 2 Annapolis, MD</u>				<b>Address</b>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>434.4</u> <u>cardiac</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u> sudden</u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>				<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)				<b>20f. (City or town)</b> (County) (State)					
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
<b>ACTUAL SIGNATURE</b> <u>E. Linhardt</u>						<b>M.D. CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>						<b>DATE SIGNED</b> <u>8/16/60</u>			
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>				<b>22b. DATE THEREOF</b> <u>AUG 20, 1960</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>BALTIMORE NATIONAL</u>				<b>22d. LOCATION</b> (City, town, or county) (State) <u>BALTIMORE, MD.</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Hopping Funeral Home</u>						<b>ADDRESS</b> <u>Annapolis, Maryland</u>				<b>24a. REC'D BY REGISTRAR</b> <b>DATE</b> <u>AUG 18 '60</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur S. Kraus</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

100710

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DECEASED NAME SEX AGE RACE OCCUPATION RESIDENCE DATE OF DEATH PLACE OF DEATH TIME OF DEATH CAUSE OF DEATH MANNER OF DEATH SIGNATURE OF EXAMINER OFFICE OF EXAMINER		MEDICAL HISTORY PRESENT ILLNESS PREVIOUS ILLNESSES SURGERY DRUGS ALCOHOL TOBACCO OTHER HABITS SIGNATURE OF WITNESS OFFICE OF WITNESS	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

1  
8778  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
08747

1. PLACE OF DEATH a. COUNTY <u>A. A.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ferndale</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Locheam</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>200 Chalmers Ave.</u>				d. STREET ADDRESS <u>3619 Campfield Rd.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>E.</u> Last <u>ROBEY</u>		4. DATE OF DEATH Month <u>Aug.</u> Day <u>6</u> Year <u>1960</u>					
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 23, 1885</u>	9. AGE (In years last birthday) <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Percy Darnell</u>			14. MOTHER'S MAIDEN NAME <u>Mary Simons</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Mr. Raymond Robey - 200 Chalmers Ave. Ferndale</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> DUE TO <u>430-1</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) <u>CORONARY ATHEROSCLEROSIS</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) INTERVAL BETWEEN ONSET AND DEATH <u>IMMED.</u> <u>5 YRS</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-5</u> 19 <u>60</u> , to <u>8-6</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>8-5</u> 19 <u>60</u> and that death occurred at <u>10:50 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Leon C. Perry,</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8-8-60</u>	
22c. PHYSICIAN'S NAME (Type) <u>Leon C. Perry,</u>				22d. ADDRESS <u>201 B+A BLVD, GLEN BURNIE, MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/9/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Western Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner &amp; Sons - Balto. Md.</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 8 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Hines</u>	

08733

CERTIFICATE OF DEATH

8133



1. Name of deceased: [illegible]  
2. Sex: [illegible]  
3. Age: [illegible]  
4. Date of birth: [illegible]  
5. Date of death: [illegible]  
6. Place of death: [illegible]  
7. Cause of death: [illegible]  
8. Signature of physician: [illegible]  
9. Signature of registrar: [illegible]  
10. Date of registration: [illegible]

CHIEF CLERK

NOTARY

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8725

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08748

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. Anne Arundel Gen.</u>				d. STREET ADDRESS <u>3311 E. Pratt Street</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>G.</u> Last <u>Rowssos</u>				4. DATE OF DEATH Month <u>8</u> Day <u>14</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 25, 1895</u>	9. AGE (In years last birthday) <u>65</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pipe Fitter</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Greece</u>		
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>							
13. FATHER'S NAME <u>?</u>			14. MOTHER'S MAIDEN NAME <u>?</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>			16. SOCIAL SECURITY NO. <u>212-09-1383</u>		17. INFORMANT <u>Mrs. Anna Rowssos, 3311 E. Pratt Street</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac disease</u> <u>434.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u></u> (c) <u></u> DUE TO (a) <u></u> (b) <u></u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour <u>o. m.</u> <u>p. m.</u> <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. L. Hardy</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>8/14/60</u>		
EXAMINER'S NAME (Type) <u>E. L. Hardy</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8-18-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadowridge Memorial</u>		22d. LOCATION (City, town, or county) (State) <u>Howard County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lilly &amp; Zeiler Inc. 1901 Eastern Ave.</u>				24a. REC'D BY REGISTRAR <u>AUG 16 60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Howard</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

8752 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]	
AGE [Faint text]		DATE OF BIRTH [Faint text]	
PLACE OF BIRTH [Faint text]		OCCUPATION [Faint text]	
MARITAL STATUS [Faint text]		CAUSE OF DEATH [Faint text]	
MANNER OF DEATH [Faint text]		MEDICAL HISTORY [Faint text]	
PRESENT ILLNESS [Faint text]		POST-MORTEM EXAMINATION [Faint text]	
SIGNATURE OF EXAMINER [Faint text]		SIGNATURE OF WITNESS [Faint text]	
DATE [Faint text]		TIME [Faint text]	
PLACE [Faint text]		COUNTY [Faint text]	
STATE [Faint text]		CITY [Faint text]	

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MARLEY PARK GLEN BURNIE 2 YRS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MARLEY PARK GLEN BURNIE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Residence</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MINNIE G. Samuelson</u>		4. DATE OF DEATH Month Day Year <u>Aug 4 - 19 60</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MARCH 2-1880-80</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Talbot Co., Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>P. J. Gambrell</u>		14. MOTHER'S MAIDEN NAME <u>(P)</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(216-07-59130)</u>	
17. INFORMANT <u>MRS. Helen L. Ruff</u>		Address <u>Raymond (same)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBAR PNEUMONIA Rt upper chest</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ARTERIOSCLEROSIS - generalized</u> DUE TO (c) <u>Heart Failure</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>July 18, 19 60</u> , to <u>Aug 4, 19 60</u> , that I last saw the deceased alive on <u>Aug 4, 19 60</u> , and that death occurred at <u>9:15 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Y. K. Yuan</u>		ADDRESS (Street, city or town, state) <u>3810 S. Hanover St. Bal 25 Md.</u>	
PHYSICIAN'S NAME (Type) <u>Y. K. YUAN</u>		DATE SIGNED <u>Aug 5, 60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>May 9 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HOLY CROSS Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>BROOKLYN BACON MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Evans</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	
ADDRESS <u>140 S. CHARLES ST.</u>		DATE <u>AUG 8 '60</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







8736

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>A. A.</b>				b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Severna Park</b>				c. LENGTH OF STAY IN 1b				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>				b. COUNTY <b>Baltimore (27)</b>															
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION								d. STREET ADDRESS <b>5512 Carville Ave.</b>								e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <b>BERTHA</b>				First <b>BERTHA</b>				Middle <b>M.</b>				Last <b>SAPPINGTON</b>				4. DATE OF DEATH Month <b>Aug.</b>				Day <b>30,</b>				Year <b>1960</b>							
5. SEX <b>female</b>				6. COLOR OR RACE <b>white</b>				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>Feb. 6, 1898</b>				9. AGE (In years lost birthday) <b>62</b> yrs.				IF UNDER 1 YEAR Months Days Hours Min.				IF UNDER 24 HRS.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>								10b. KIND OF BUSINESS OR INDUSTRY								11. BIRTHPLACE (State or foreign country) <b>Md.</b>								12. CITIZEN OF WHAT COUNTRY? <b>Hones</b>							
13. FATHER'S NAME <b>Charles Schellor</b>												14. MOTHER'S MAIDEN NAME <b>Maria Elisa Hoenes</b>																			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)								16. SOCIAL SECURITY NO.								INFORMANT <b>Dr. Robert Hahn - Severna Park, Md.</b>								Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive C.V. Disease</b> DUE TO (c)																INTERVAL BETWEEN ONSET AND DEATH															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19								20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>								20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)								20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>1954</b> , 19 to <b>1960</b> , 19, that I last saw the deceased alive on <b>8-30-60</b> , 19, and that death occurred at <b>5:30 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Severna Park, Md.</b> DATE SIGNED <b>8-30-60</b> ACTUAL SIGNATURE <b>Robert R. Hahn</b> M.D. PHYSICIAN'S NAME (Type) <b>Robert R. Hahn</b>																															
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>								22b. DATE THEREOF <b>9/2/60</b>								22c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>								22d. LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Tickner &amp; Son - Radio</b>																24a. REC'D BY REGISTRAR DATE <b>AUG 31 '60</b>								24b. REGISTRAR'S SIGNATURE <b>Arthur S. Howard</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00750

CERTIFICATE OF DEATH

8436

1. Name of deceased - [illegible]

2. Date of death - [illegible]

1

**MARYLAND STATE DEPARTMENT OF HEALTH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

8726

08751

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN lb <b>2 Wkks.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Sarah Jane Scales</b>				4. DATE OF DEATH <b>August 30 1960</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug. 13-1876</b>	
9. AGE (In years last birthday) <b>84</b>		10. IF UNDER 1 YEAR Months <b>8</b> Days <b>15</b> Hours <b>42</b> Min.		11. IF UNDER 24 HRS. Hours <b>15</b> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laundry</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>*****</b>			
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZENSHIP <b>Anne Arundel</b>			
13. FATHER'S NAME <b>Benjamin Scales</b>				14. MOTHER'S MAIDEN NAME <b>Malinda Baker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>Unknown</b>			
17. INFORMANT <b>Charlotte Johnson - 32 Clay St. Anna. Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>442X</b> DUE TO <b>Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. } (b) <b>Hypertension Cardio Vascular Disease</b> (c) <b>Nephrosclerosis &amp; Ren. Arteriosclerosis</b>							INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b> <b>15 yr.</b> <b>10 yr.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>8/10</b> to <b>8/30</b> , 19 <b>60</b> that (I) (we) last saw the deceased alive on <b>8/30</b> , 19 <b>60</b> and that death occurred on <b>8/30</b> , 19 <b>60</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Theodore H. Johnson</b> M.D.				22b. ADDRESS <b>Calvert St., Annapolis, Md.</b>			
22c. PHYSICIAN'S NAME (Type) <b>Dr. Theodore H. Johnson</b>				22d. ADDRESS <b>Calvert St., Annapolis, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Sept. 2-60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Brewer Hill</b>		23d. LOCATION (City, town, or county) (State) <b>Annapolis, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>C.E. Hick</b> <b>111</b> <b>Annapolis, Md.</b>				25a. REC'D BY REGISTRAR <b>SEP 1 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. House</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15330

CERTIFICATE OF DEATH

15330



Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.



Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Page 4

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TSM 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08752

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>10</b> <b>Annapolis</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Richard</b> Middle <b>GREEN</b> Last <b>SCIBLE</b>		4. DATE OF DEATH Month <b>August</b> Day <b>2</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 3, 1885</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months <b>75</b> Days <b>75</b> Hours <b>75</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lumber Hardware</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John H. Scible</b>		14. MOTHER'S MAIDEN NAME <b>Georgina Collinson</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Sarah E. Scible</b>		Address <b>(2)</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Unrestrained</b> DUE TO (b) <b>Carcinoma of prostate</b> DUE TO (c) <b>lymphoma</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>4/50</b> 19 to <b>8/2/60</b> 19, that (I) <b>last</b> saw the deceased alive on <b>8/2/60</b> 19, and that death occurred at <b>M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Edwin Davis, Jr.</b>		22b. DATE SIGNED <b>8/2/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Edwin Davis, Jr.</b>		22d. ADDRESS <b>98 Cathedral St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug 5<sup>th</sup> 60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Memorial</b>		23d. LOCATION (City, town, or county) (State) <b>Annapolis Md</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>John M. Saylor</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 4 '60</b>	
25b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>			

08185

CERTIFICATE OF DEATH

8185



Blank lines for text entry, including fields for name, date, and other details.

STAMPED DATE



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)  
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

8728

08753

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John</b> <b>(NMI)</b> <b>SEDLMAIER</b>		4. DATE OF DEATH <b>August 19 19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 2, 1900</b>
9. AGE (In years lost birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Paul Hetlick Co.</b>	
11. BIRTHPLACE (State or foreign country) <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN SEDLMAIER</b>		14. MOTHER'S MAIDEN NAME <b>ANNA ADELMANN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-14-5187</b>	
17. INFORMANT <b>Mrs. Katherine L. Sedlmaier, 808 Sligo Ave.</b>		Address <b>Silver Spring</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Spontaneous rupture of</b> <b>451X</b> DUE TO <b>Aortic Aneurysm with</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. } DUE TO <b>Internal Hemorrhage</b> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerotic Cardio-Vascular Disease</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 7, 1960</b> to <b>Aug. 9, 1960</b> , that (I) <b>did</b> last saw the deceased alive on <b>Aug. 9, 1960</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Albert H. Anderson</b>		22b. DATE SIGNED <b>8/10/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. L. Anderson</b>		22d. ADDRESS <b>44 Southgate Ave., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8/13/60</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>PROSPECT HILL CEMETERY</b>		23d. LOCATION (City, town, or county) (State) <b>WASHINGTON, D.C.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Raymond E. Pumphrey, INC.</b>		25a. REC'D BY REGISTRAR <b>DATE AUG 15 '60</b>	
ADDRESS <b>SILVER SPRING, MD.</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



VS. A15ME  
5M 7/59

1. PLACE OF DEATH a. COUNTY <u>A. Acc.</u>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. LENGTH OF STAY IN 1b <u>03522</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>		d. STREET ADDRESS <u>23 Somerset Road</u>	
3. NAME OF DECEASED (Type or print) <u>Louise L. Sedwick</u>		4. DATE OF DEATH <u>August 18, 1960</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>4/2/1894</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		10. IF UNDER 1 YEAR Months <u>66</u> Days <u>66</u>	
11. IF UNDER 24 HRS. Hours <u>66</u> Min. <u>66</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jos. B. Lambert</u>		14. MOTHER'S MAIDEN NAME <u>Emma Jane Paynter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mr. Jos. B. Lambert - 342 E. University Pkwy.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Disease</u> 434-4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>E. L. Barrett</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>E. L. Barrett</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>8/18/60</u>	
Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/22/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>		22d. LOCATION (City, town, or country) _____ (State) _____	
23. FUNERAL DIRECTOR <u>Wm. F. Pickens &amp; Sons</u>		24a. REGISTRY REGISTRAR <u>Aug 23 60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

115520

8152



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8730

## CERTIFICATE OF DEATH

08755

  

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Anne Arundel</u></span>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			c. LENGTH OF STAY IN 1b <u>40 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>3 Carver Street</u>				d. STREET ADDRESS <u>3 Carver Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
<b>3. NAME OF DECEASED</b> (Type or print) <u>William</u> <span style="float: right;">First</span> <u>McClain</u> <span style="float: right;">Middle</span> <u>Simms</u> <span style="float: right;">Last</span>				<b>4. DATE OF DEATH</b> <span style="float: right;">Month</span> <u>August</u> <span style="float: right;">Day</span> <u>10</u> <span style="float: right;">Year</span> <u>1960</u>				
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>Colored</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>February 28, 1905</u>		
<b>9. AGE</b> (In years last birthday) <u>55</u> yrs.		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Deliveryman</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Annapolis, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		
<b>13. FATHER'S NAME</b> <u>McClain Simms</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Georganna Howard</u>				
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>213-16-4593</u>		<b>17. INFORMANT</b> <u>Eleanor Simms- 3 Carver St. Annapolis, Md.</u> <span style="float: right;">Address</span>				
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Convulsions</u> <u>199.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)				
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <u>May</u> , 19 <u>69</u> , to <u>Aug. 10</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>August 10</u> , 19 <u>60</u> , and that death occurred at <u>4:50 P.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ <b>ACTUAL SIGNATURE</b> <u>R.L. Richardson</u> <span style="float: right;">M.D.</span> _____ <b>PHYSICIAN'S NAME (Type)</b> <u>R.L. Richardson</u> <span style="float: right;">Clay st. Annapolis, Maryland</span>								
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>August 13, 1960</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Brewer Hill</u>		<b>22d. LOCATION</b> (City, town, or county) (State) <u>Annapolis A. A., Maryland</u>		
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>G. E. Hicks 111</u> <span style="float: right;">ADDRESS</span> <u>Annapolis, Maryland</u>				<b>24a. REC'D BY REGISTRAR</b> <u>AUG 16 '60</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kline</u>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



08333

CERTIFICATE OF DEATH

24111

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65		4. DATE OF BIRTH 1904		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Carpenter		7. MARITAL STATUS Married		8. EDUCATION High School		9. RELIGION Roman Catholic		10. RACE White	
11. DATE OF DEATH 1969		12. TIME OF DEATH 10:15 AM		13. PLACE OF DEATH Home		14. CAUSE OF DEATH Heart Disease		15. MANNER OF DEATH Natural	
16. SIGNATURE OF PHYSICIAN J. H. Harris		17. SIGNATURE OF REGISTRAR J. H. Harris		18. SIGNATURE OF WITNESS J. H. Harris		19. SIGNATURE OF DECEASED J. H. Harris		20. SIGNATURE OF NEXT OF KIN J. H. Harris	
21. SIGNATURE OF DECEASED J. H. Harris		22. SIGNATURE OF NEXT OF KIN J. H. Harris		23. SIGNATURE OF DECEASED J. H. Harris		24. SIGNATURE OF NEXT OF KIN J. H. Harris		25. SIGNATURE OF DECEASED J. H. Harris	

10

THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, BALTIMORE, MD, AND A COPY OF THE SAME IS TO BE FURNISHED TO THE COUNTY CLERK OF THE COUNTY IN WHICH THE DECEASED RESIDES.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8781

## CERTIFICATE OF DEATH

Reg. Dist. 08757

1. PLACE OF DEATH o. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WEEMS CREEK, ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>WEEMS CREEK</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>HENRY</u> Last <u>SMITH</u>				4. DATE OF DEATH Month <u>AUGUST</u> Day <u>2</u> Year <u>1960</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 27, 1874</u>		9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months <u>85</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired General</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Labora US Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William J. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Virginia Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>John W. Smith- Son- Same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Heart Failure</u> DUE TO <u>Arteriosclerotic C. V. Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic C. V. Disease</u> DUE TO (c) <u>Arteriosclerotic C. V. Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 mo.</u> <u>4 mo.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> 19 <u>  </u> to <u>Aug 2, 1960</u> , that I last saw the deceased alive on <u>August 2, 1960</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>31 Southgate Ave. Annapolis, Maryland</u> DATE SIGNED <u>8/3/60</u>							
ACTUAL SIGNATURE <u>Maurice F. Klawans</u> M.D. <u>3</u>				PHYSICIAN'S NAME (Type) <u>MAURICE F. KLAWANS MD.</u> <u>31 Southgate Ave. Annapolis, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug. 5, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping Funeral Home</u>				24a. REC'D BY REGISTRAR DATE <u>AUG 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraw</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: A death certificate must be signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

8781

88257

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Jan 15 1918</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. DISEASE OR INJURY <i>Myocardial Infarction</i>		9. MANNER OF DEATH <i>Natural</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Smith</i>		11. SIGNATURE OF WITNESSES <i>John Doe, Jr.</i> <i>John Doe, Sr.</i>		12. SIGNATURE OF CORONER <i>John Doe</i>	
13. SIGNATURE OF REGISTRAR <i>John Doe</i>		14. SIGNATURE OF CLERK <i>John Doe</i>		15. SIGNATURE OF JURY <i>John Doe</i>	
16. SIGNATURE OF JURY <i>John Doe</i>		17. SIGNATURE OF JURY <i>John Doe</i>		18. SIGNATURE OF JURY <i>John Doe</i>	
19. SIGNATURE OF JURY <i>John Doe</i>		20. SIGNATURE OF JURY <i>John Doe</i>		21. SIGNATURE OF JURY <i>John Doe</i>	
22. SIGNATURE OF JURY <i>John Doe</i>		23. SIGNATURE OF JURY <i>John Doe</i>		24. SIGNATURE OF JURY <i>John Doe</i>	
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40. SIGNATURE OF JURY <i>John Doe</i>		41. SIGNATURE OF JURY <i>John Doe</i>		42. SIGNATURE OF JURY <i>John Doe</i>	
43. SIGNATURE OF JURY <i>John Doe</i>		44. SIGNATURE OF JURY <i>John Doe</i>		45. SIGNATURE OF JURY <i>John Doe</i>	
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52. SIGNATURE OF JURY <i>John Doe</i>		53. SIGNATURE OF JURY <i>John Doe</i>		54. SIGNATURE OF JURY <i>John Doe</i>	
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73. SIGNATURE OF JURY <i>John Doe</i>		74. SIGNATURE OF JURY <i>John Doe</i>		75. SIGNATURE OF JURY <i>John Doe</i>	
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79. SIGNATURE OF JURY <i>John Doe</i>		80. SIGNATURE OF JURY <i>John Doe</i>		81. SIGNATURE OF JURY <i>John Doe</i>	
82. SIGNATURE OF JURY <i>John Doe</i>		83. SIGNATURE OF JURY <i>John Doe</i>		84. SIGNATURE OF JURY <i>John Doe</i>	
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88. SIGNATURE OF JURY <i>John Doe</i>		89. SIGNATURE OF JURY <i>John Doe</i>		90. SIGNATURE OF JURY <i>John Doe</i>	
91. SIGNATURE OF JURY <i>John Doe</i>		92. SIGNATURE OF JURY <i>John Doe</i>		93. SIGNATURE OF JURY <i>John Doe</i>	
94. SIGNATURE OF JURY <i>John Doe</i>		95. SIGNATURE OF JURY <i>John Doe</i>		96. SIGNATURE OF JURY <i>John Doe</i>	
97. SIGNATURE OF JURY <i>John Doe</i>		98. SIGNATURE OF JURY <i>John Doe</i>		99. SIGNATURE OF JURY <i>John Doe</i>	
100. SIGNATURE OF JURY <i>John Doe</i>		101. SIGNATURE OF JURY <i>John Doe</i>		102. SIGNATURE OF JURY <i>John Doe</i>	

**CERTIFICATE OF DEATH**  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

8731

08758

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis, Baltimore</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>				d. STREET ADDRESS <b>3013 Weaver Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Albert</b> Middle <b>STANEK</b> Last <b>STANEK</b>				4. DATE OF DEATH Month <b>August</b> Day <b>30</b> Year <b>1960</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 23, 1870</b>		9. AGE (In years last birthday) <b>90</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cooper U.S. Industrial Alcohol</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Czechoslovakia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Martin Stanek</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>				16. SOCIAL SECURITY NO. <input type="checkbox"/>		17. INFORMANT <b>Frank Stanek, son, 3013 Weaver Avenue</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive Heart Failure</b> DUE TO (b) <b>Arterio-sclerotic C.V. Disease</b> DUE TO (c) <b>Fracture, neck of L. femur</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH <b>1 mo.</b> <b>yes.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture, neck of L. femur</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) <b>this hospital</b> attended the deceased from <b>Aug. 1, 1960</b> to <b>Aug. 30, 1960</b> , that (I) <b>yes</b> last saw the deceased alive on <b>Aug. 30, 1960</b> , and that death occurred at <b>12:40 P.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Maurice Klawans</b>				22b. DATE <b>12:40 P.M.</b>		22c. PHYSICIAN'S NAME (Type) <b>Maurice Klawans</b>	
22d. ADDRESS <b>31 Southgate Ave., Annapolis, Md.</b>				22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>9/3/60</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cem.</b>		23d. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Schimunek Funeral Home, Inc.</b>				25a. REC'D BY REGISTRAR DATE <b>SEP 2 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

08758

CERTIFICATE OF DEATH

08758

DECEASED

NAME

DATE

AGE

SEX

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

DIAGNOSIS

REPORT

BY

DATE

PLACE

TIME

SIGNATURE OF DECEASED

WITNESSES

DATE

PLACE OF DEATH

REMARKS

REMARKS

REMARKS

REMARKS

REMARKS

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REMARKS

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REMARKS

8782

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>				c. LENGTH OF STAY IN 1b <u>10 min.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>425 Ritchie Hwy. Glen Burnie</u>				e. STREET ADDRESS <u>1 Herald Harbor Road</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>EDWARD ALLEN Stinchcomb</u>				4. DATE OF DEATH Month Day Year <u>August 3 1960</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1923</u>	9. AGE (In years last birthday) yrs. <u>37</u>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Chauffeur</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>State Roads</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Stinchcomb</u>				14. MOTHER'S MAIDEN NAME <u>Elsie Moran</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>WW 11 218-14-2124</u>		17. INFORMANT Address <u>Leonard Stinchcomb, Crownsville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>1-2 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I attended the deceased from <u>8/3</u> , 19 <u>60</u> , to <u>8/3</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>8/3</u> , 19 <u>60</u> , and that death occurred at <u>9:57</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>Ernest A. Leipold</u>		M.D. _____					
PHYSICIAN'S NAME (Type) <u>Ernest A. Leipold, M.D.</u>		<u>Arundel Med. Grp., Glen Burnie, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8/6/60</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Memorial</u>	22d. LOCATION (City, town, or county) (State) <u>Glen Burnie Md.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley</u>			ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>AUG 5 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

08759

MARYLAND STATE OF MENTAL HEALTH - BALTIMORE 18

## CERTIFICATE OF DEATH

Page One of Two

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. DATE OF BIRTH May 19, 1928		4. PLACE OF BIRTH Jackson, Tennessee	
5. OCCUPATION None		6. MARITAL STATUS Single		7. COLOR White		8. HEIGHT 5' 11"	
9. WEIGHT 175		10. HAIR Brown		11. EYES Blue		12. BUILD Slender	
13. EDUCATION High School		14. RELIGION Methodist		15. SOCIAL SECURITY NUMBER [Redacted]		16. MOTHER'S MAIDEN NAME [Redacted]	
17. DATE OF DEATH June 4, 1968		18. PLACE OF DEATH Baltimore, Maryland		19. CAUSE OF DEATH [Redacted]		20. MANNER OF DEATH Suicide	
21. SIGNATURE OF DECEASED [Redacted]		22. SIGNATURE OF WITNESS [Redacted]		23. SIGNATURE OF PHYSICIAN [Redacted]		24. SIGNATURE OF CORONER [Redacted]	
25. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]		26. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]		27. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]		28. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]	
29. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]		30. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]		31. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]		32. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]	
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37. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]		38. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]		39. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]		40. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]	
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61. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]		62. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]		63. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]		64. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]	
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69. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]		70. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]		71. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]		72. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]	
73. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]		74. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]		75. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]		76. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]	
77. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]		78. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]		79. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]		80. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]	
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85. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]		86. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]		87. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]		88. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]	
89. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]		90. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]		91. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]		92. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]	
93. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]		94. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]		95. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]		96. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]	
97. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]		98. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]		99. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]		100. SIGNATURE OF DECEASED'S NEXT OF KIN [Redacted]	



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8732

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08760

Items 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Arnold</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Henry</b> Middle <b>Stumpf</b> Last <b>Stumpf</b>		4. DATE OF DEATH Month <b>August</b> Day <b>19</b> Year <b>1960</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>17 Aug. 1877</b>
9. AGE (In years last birthday) <b>83</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Frederick Stumpf</b>	
14. MOTHER'S MAIDEN NAME <b>Unknown</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>	
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Mr. Elwood Stumpf #5 Grandview Rd., Arnold, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO <b>177X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Metastases</b> DUE TO <b>CA Prostate</b> (c) <b>unk.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>7/19/60</b> to <b>8/19/60</b> , that (I) (we) last saw the deceased alive on <b>8/19/60</b> , and that death occurred at <b>9A</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Edwin Davis, Jr.</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Edwin Davis, Jr.</b>		22d. ADDRESS <b>Cathedral St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <b>19 Aug. 1960</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Green Haven</b>	23d. LOCATION (City, town, or county) (State) <b>Annapolis, Md.</b>
24. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur S. Kraus</b>		25. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	
25a. REC'D BY REGISTRAR <b>AUG 22 '60</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

08566

CERTIFICATE OF DEATH

8438

*[Faint, illegible text and markings on a death certificate form, including fields for name, date, and cause of death.]*

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

08761

8783

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MD.</b> b. COUNTY <b>2V 01-4</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>JESSUP</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore City</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>MARYLAND HOUSE OF CORRECTION</b>				d. STREET ADDRESS <b>535 Wilson Court</b>			
3. NAME OF DECEASED (Type or print) First <b>RUDOLPH</b> Middle <b>W.</b> Last <b>THOMAS</b>				4. DATE OF DEATH Month <b>August</b> Day <b>22</b> Year <b>1960</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>N</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>July 9, 1907</b>	
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months <b>53</b> Days <b>53</b> Hours <b>53</b> Min.		10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SIMPSONVILLE MD</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>JAMES R. THOMAS</b>				14. MOTHER'S MAIDEN NAME <b>ADDIE GALLOWAY</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>9 yrs.</b>		17. INFORMANT Address <b>May Connors down - 1542 Bruce St.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>420.1</b> DUE TO <b>CORONARY THROMBOSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>46 days</b> (c)						INTERVAL BETWEEN ONSET AND DEATH <b>46 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>July 7, 1960</b> to <b>Aug. 22, 1960</b> , that I last saw the deceased alive on <b>Aug. 22, 1960</b> , and that death occurred at <b>6:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Baltimore MD</b> DATE SIGNED <b>Quinton L. Lilly</b>							
ACTUAL SIGNATURE <b>Quinton L. Lilly</b> M.D.							
PHYSICIAN'S NAME (Type) <b>QUINTON L. LILLY</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>8/27/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>MT HUBURN</b>		22d. LOCATION (City, town, or county) (State) <b>BALTIMORE MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Marshall P. Thompson</b>				ADDRESS <b>638 N. Gilman St</b>		24a. REC'D BY REGISTRAR <b>DATE AUG 25 '60</b>	
24b. REGISTRAR'S SIGNATURE <b>Quinton L. Lilly</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8784

CERTIFICATE OF DEATH

Reg. Dist. No. 08762

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Green Haven</u>				c. LENGTH OF STAY IN 1b <u>10 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>				d. STREET ADDRESS <u>Catherine St.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Herbert E. Ernest Tribett</u>				4. DATE OF DEATH <u>AUG. 30 1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 18 1878</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad Conductor (ret.)</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>RR</u>			
11. BIRTHPLACE (State or foreign country) <u>Meggs Ohio</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>George W. Tribett</u>				14. MOTHER'S MAIDEN NAME <u>unknown Johnson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>705-07-5765</u>			
17. INFORMANT <u>Belmar Tribett</u>				Address <u>Green Haven Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Carcinomatosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gastric Carcinoma</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from <u>JAN 1956</u> , 19____, to <u>AUG 1960</u> , 19____, that I last saw the deceased alive on <u>AUG 29</u> , 19 <u>60</u> , and that death occurred at <u>2:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>2934 MOUNTAIN RD.</u> DATE SIGNED <u>8-30-60</u> ACTUAL SIGNATURE <u>Arthur Lankford Jr.</u> PHYSICIAN'S NAME (Type) <u>ARTHUR LANKFORD JR. PASADENA, MD.</u> 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Sept. 3, 1960</u> 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY <u>North View Cemetery</u> 22d. LOCATION (City, town, or county) (State) <u>New Martinsville W. Va.</u> 23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard V. Singleton</u> ADDRESS <u>Glen Burnie, Md.</u> 24a. REC'D BY REGISTRAR <u>SEP 2 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>							

# CERTIFICATE OF DEATH

7-184

NAME OF DECEASED: JOSEPHINE S. SORIANO SEX: F AGE: 45 YEARS

DATE OF DEATH: 1945 PLACE OF DEATH: MANILA

CAUSE OF DEATH: HEART DISEASE

DATE OF BIRTH: 1900 PLACE OF BIRTH: MANILA

EDUCATION: Elementary OCCUPATION: Housewife

RELIGION: Catholic MARITAL STATUS: Married

NAME OF SPOUSE: JOSE SORIANO

NAME OF CHILDREN: None

NAME OF NEXT OF KIN: None

NAME OF PHYSICIAN: Dr. S. S. SORIANO

NAME OF NURSE: None

NAME OF MIDWIFE: None

NAME OF ATTENDING PHYSICIAN: Dr. S. S. SORIANO

NAME OF ATTENDING NURSE: None

NAME OF ATTENDING MIDWIFE: None

NAME OF ATTENDING PHYSICIAN: Dr. S. S. SORIANO

NAME OF ATTENDING NURSE: None

NAME OF ATTENDING MIDWIFE: None

NAME OF ATTENDING PHYSICIAN: Dr. S. S. SORIANO

NAME OF ATTENDING NURSE: None

NAME OF ATTENDING MIDWIFE: None

NAME OF ATTENDING PHYSICIAN: Dr. S. S. SORIANO

NAME OF ATTENDING NURSE: None



1  
#

8785

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08763

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel Co</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Millersville Md</i>		c. LENGTH OF STAY IN 1b <i>38 day</i> X <i>Odenton</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Knollwood Manor</i>		d. STREET ADDRESS <i>200 King Malcom Ave</i>	
3. NAME OF DECEASED (Type or print) <i>Olive T. McKee</i> First <i>Tuckey</i> Last		4. DATE OF DEATH <i>8/7/1960</i> Month <i>8</i> Day <i>7</i> Year <i>1960</i>	
5. SEX <i>F</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10/22/1876</i>
9. AGE (In years lost birthday) <i>83</i> yrs.		10. IF UNDER 1 YEAR Months <i>1</i> Days <i>1</i>	11. IF UNDER 24 HRS. Hours <i>1</i> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or if retired) <i>News paper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Cambridge, Ohio</i>	
11. BIRTHPLACE (State or foreign country) <i>USA.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
13. FATHER'S NAME <i>John R. Morehead</i>		14. MOTHER'S MAIDEN NAME <i>Jane Morehead</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>	
17. INFORMANT <i>Knollwood Manor</i>		Address <i>Millersville Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Labor Pneumonia</i> 422.1 DUE TO <i>Cardio Vax Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Semility</i> DUE TO (c) <i>—</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>One Rectal Fistula</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month <i>6</i> Day <i>29</i> Year <i>1960</i> Hour <i>a. m.</i> <i>8</i> p. m. <i>7</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City as town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>6/29/60</i> to <i>8/7/60</i> , that (I) (we) last saw the deceased alive on <i>8/6/60</i> , and that death occurred at <i>11 AM</i> from the causes and on the date stated above.			
22a. SIGNATURE <i>DR. JOSEPH LIPSKEY</i> M.D.		22b. DATE SIGNED <i>8/7/60</i>	
22c. PHYSICIAN NAME (Type) <i>ODENTON, MARYLAND</i>		22d. ADDRESS <i>Odenton, Md.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE THEREOF <i>12 August 1960</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Greenlawn Cemetery</i>	23d. LOCATION (City, town, or county) (State) <i>Columbus, Ohio</i>
24. FUNERAL DIRECTOR'S SIGNATURE <i>P. V. Knighton</i>		25a. REC'D BY REGISTRAR <i>Arthur S. Kraus</i>	
ADDRESS <i>Glen Burnie, Md.</i>		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	
DATE <i>AUG 11 '60</i>			

MEDICAL CERTIFICATION

108783

UNITED STATES OF AMERICA

108783

(M)

(I)

*[Faint, mostly illegible handwritten text, possibly a letter or report, covering the majority of the page.]*

DR. JOSEPH L. ROBERT  
CHIEF OF BUREAU

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dis. No. 08764

8733

1. PLACE OF DEATH a. COUNTY <u>AA</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u>10</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>401 Severn Ave</u>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>AA</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>1401 Severn Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Linda Virginia Warram</u> First Middle Last		4. DATE OF DEATH Month <u>8</u> Day <u>17</u> Year <u>1960</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 17<sup>th</sup> 1958</u>
9. AGE (In years last birthday) <u>1</u> yrs. <u>11</u> Months <u>1</u> Days <u></u> Hours <u></u> Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Leonard W. Warram</u>	
14. MOTHER'S MAIDEN NAME <u>Yonko Koshunaka</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> (If yes, give war or dates of service) <u>-</u>	
16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>Leonard W. Warram</u> Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sepsis</u> <u>922.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u> sudden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Ingestion of Kleenex with aspiration of vomitus producing - occlusion Air way</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Annapolis</u> <u>AA</u> <u>Md.</u>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>E. Linhardt</u> EXAMINER'S NAME (Type) <u>E. Linhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>8/17/60</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>8-19-1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Naval Academy</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis</u> <u>Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor, Son</u>		24a. REC'D BY REGISTRAR <u>DATE AUG 22 '60</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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8734  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

08765

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>2 mos. 5 da.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel General Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL - Edgewater,</b>	
f. STREET ADDRESS <b>Cape Loch Haven, Rt-3, Box-880</b>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>REUBEN Rubin</b> First <b>L.</b> Middle <b>WASTLER</b> Last		4. DATE OF DEATH Month <b>August</b> Day <b>5</b> Year <b>19 60</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 1, 1902</b>
9. AGE (In years last birthday) <b>57</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MAINTENANCE MAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>LANDSCAPING</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTO. MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>NEWTON S. WASTLER</b>		14. MOTHER'S MAIDEN NAME <b>MOLLY HIBERDER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>(Yes, give war or dates of service)</b>		16. SOCIAL SECURITY NO. <b>214-03-9397</b>	
17. INFORMANT <b>MRS. ROSE E. WASTLER #2</b>		Address	
18. CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>157X</b> IMMEDIATE CAUSE (a) <b>Carcinoma of pancreas -</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>3 yrs.</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>May 31, 19 60</b> , to <b>Aug. 5, 19 60</b> , that (I) <b>did</b> last saw the deceased alive on <b>Aug. 5, 19 60</b> , and that death occurred at <b>6:00 P.M.</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Richard N. Peeler</b>		22b. DATE SIGNED <b>8/9/60</b>	
22c. PHYSICIAN'S NAME (Type) <b>Richard N. Peeler</b>		22d. ADDRESS <b>121 Cathedral St., Annapolis, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Aug 9th 1960</b>		23b. DATE THEREOF <b>HILLCREST MEM</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ANNAPOLIS MD</b>		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <b>JOHN M. TAYLOR SONS</b>		25a. REC'D BY REGISTRAR <b>AUG 10 '60</b>	
ADDRESS <b>ANNAPOLIS MD</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur L. Hume</b>	



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DEPARTMENT OF HEALTH

8784

State of New York

County of ...

City of ...

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## CERTIFICATE OF DEATH

Reg. Dist. 08766

1. PLACE OF DEATH a. COUNTY <u>aa</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>aa</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delby on the Bay</u>				c. LENGTH OF STAY IN 1b <u>X</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Delby on the Bay</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delby on the Bay</u>			
f. STREET ADDRESS <u>Pt 1 Box 253 Edgewater Md</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Elizabeth C. Whalen</u>				4. DATE OF DEATH <u>Aug. 25</u> 19 <u>60</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-3-1907</u>	
9. AGE (In years last birthday) <u>53</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Waltman</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth King</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>-</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>			
17. INFORMANT <u>Catherine Weed</u>				(2)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pneumonitis + cardiac failure</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic hypertensive cardio-vascular disease and</u> (c) <u>brain tumor</u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>3 years.</u> <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Aug. 1</u> , 19 <u>59</u> , to <u>Aug. 25</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Aug. 25</u> , 19 <u>60</u> , and that death occurred at <u>6:50 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Sylvia M. Lim</u> M.D.				ADDRESS (Street, city or town, state) <u>RFD #1 Box 222-M. Edgewater Md.</u>			
PHYSICIAN'S NAME (Type) <u>Sylvia M. Lim</u>				DATE SIGNED <u>8/26/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Aug 29-1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Stephens Church Mt.</u>		22d. LOCATION (City, town, or county) <u>Bradshaw Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u> ADDRESS <u>San Annapolis Md</u>				24a. REC'D BY REGISTRAR <u>Aug 30 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: All this certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with information regarding the deceased. Pages 3 and 4 should be filled with information regarding the funeral and burial. This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18																			
Items 5,6,7 Film G269 8-29-60 et																			
8787																			
CERTIFICATE OF DEATH																			
Reg. Dist. No. 08767																			
1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Q.A.</u>														
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Galesville</u>					c. LENGTH OF STAY IN IB <u>71</u>														
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
3. NAME OF DECEASED (Type or print) <u>William F</u> First <u>Woodfield</u> Middle Last					4. DATE OF DEATH <u>Aug.</u> <u>19</u> <u>1960</u> Month Day Year														
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 23, 1888</u>		9. AGE (In years last birthday) <u>71</u> yrs.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Woodfield Fish &amp; Oyster Co. Seafood</u>					10b. KIND OF BUSINESS OR INDUSTRY <u>Galesville</u>														
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>					12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>														
13. FATHER'S NAME <u>William A Woodfield</u>					14. MOTHER'S MAIDEN NAME <u>Ida B. Seigert</u>														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>WW I</u>					16. SOCIAL SECURITY NO. <u>Nina E. Woodfield</u>														
17. INFORMANT <u>Nina E. Woodfield</u> Address																			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u> DUE TO 42001 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerotic heart disease</u> DUE TO (c) <u>coronary thrombosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>bronchial asthma</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u> <u>1950</u> <u>1955</u>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>					20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)																			
21. I certify that I attended the deceased from <u>1941</u> , 19____, to <u>Aug. 19</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Aug. 18</u> , 19 <u>60</u> , and that death occurred at <u>9:57 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Amos Garrett Blvd.</u> DATE SIGNED <u>8/22/60</u>																			
ACTUAL SIGNATURE <u>S. Borssuck</u> M.D. <u>Amos Garrett Blvd.</u> <u>8/22/60</u>																			
PHYSICIAN'S NAME (Type) <u>S. Borssuck, M.D.</u> <u>Annapolis, Md.</u>																			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>					22b. DATE THEREOF <u>Aug 23, 1960</u>					22c. NAME OF CEMETERY OR CREMATORY <u>Quaker</u>									
22d. LOCATION (City, town, or county) <u>Galesville</u>					22e. (State) <u>Md.</u>														
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard A. O. Hardwick</u> ADDRESS <u>Galesville Md.</u>					24a. REC'D BY REGISTRAR <u>Aug 25 '60</u>					24b. REGISTRAR'S SIGNATURE <u>Charles S. Krawiec</u>									

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Page 4  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

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8788  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

08768

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Q. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sevema Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sevema Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Box # 383</u>				d. STREET ADDRESS <u>1 Rt 2 Box # 261</u>			
3. NAME OF DECEASED (Type or print) <u>Thelma Mae Wright</u>				4. DATE OF DEATH <u>Aug 8 1960</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>SEPT 16, 1921</u>	
9. AGE (In years last birthday) <u>38</u> yrs.		10. UNDER 1 YEAR <u>38</u> Months		11. UNDER 24 HRS. <u>38</u> Days		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DEFENSE WORK</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>G.I. MARTIN</u>			
13. FATHER'S NAME <u>CHARLES HOWARD LINDEMORE</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Banks</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>29-18-411</u>			
17. INFORMANT <u>FAMILY</u>				Address <u>ABOVE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral hemorrhage</u> DUE TO <u>arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Tuberculous meningitis</u> DUE TO (c) <u>8 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u> INTERVAL BETWEEN ONSET AND DEATH <u>30 mins</u> <u>1 year</u> <u>8 years</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Apr. 15 1958</u> to <u>August 8 1960</u> , that (I) (we) last saw the deceased alive on <u>August 8 1960</u> and that death occurred at <u>8</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>R. M. McLaughlin</u>				22b. DATE <u>Aug. 8, 1960</u>			
22c. PHYSICIAN'S NAME (Type) <u>R. M. McLaughlin</u>				22d. ADDRESS <u>3708 Mountain Rd. Pasadena, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8-11-60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BALTO. GEM.</u>		23d. LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Robert S. Banana</u>				25a. REC'D BY REGISTRAR <u>Arthur S. Hines</u>			
ADDRESS <u>Sevema Park, Md.</u>				25b. REGISTRAR'S SIGNATURE <u>Aug 12 '60</u>			



08368

8368

MADE IN GREAT BRITAIN  
CERTIFICATE OF ANALYSIS

ANALYSIS OF  
[Faint handwritten text, likely describing the sample and analysis results]

1

10

[Faint handwritten text at the bottom of the page, possibly a signature or date]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8789

## CERTIFICATE OF DEATH

Reg. Dist. No. 08769

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b> c. LENGTH OF STAY IN 1b <b>4 years 9mo. 1 day</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> d. STREET ADDRESS <b>1122 N. Fulton Avenue</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Joseph</b> Middle <b>Young</b> Last <b>Young</b>		4. DATE OF DEATH Month <b>8</b> Day <b>9</b> Year <b>1960</b>							
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>December 5, 1893</b>	9. AGE (In years lost birthday) yrs. <b>66</b>	10. IF UNDER 1 YEAR Months <b>66</b>	11. IF UNDER 24 HRS. Days <b>66</b>	12. IF UNDER 24 HRS. Hours <b>66</b>	13. IF UNDER 24 HRS. Min. <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Franklin Young</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Hospital Records</b> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bilateral Hypostatic Pneumonia</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Brain Syndrome Associated with Meningo-Vascular Syphilis</b>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>-----</b>							
20c. TIME OF INJURY Hour o. m. p. m. <b>-----</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>-----</b>		20f. (City or town) <b>-----</b>		(County) <b>-----</b>	(State) <b>-----</b>
21. I certify that I attended the deceased from <b>11/8</b> , 19 <b>55</b> , to <b>8/9</b> , 19 <b>60</b> , that I last saw the deceased alive on <b>8/9</b> , 19 <b>60</b> , and that death occurred at <b>3:30 A.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Crownsville State Hospital, Md.</b> DATE SIGNED <b>8/9/60</b>									
ACTUAL SIGNATURE <b>L. Benedict</b>		M.D. <b>Crownsville State Hospital, Md.</b>		8/9/60					
PHYSICIAN'S NAME (Type) <b>L. Benedict, M. D.</b>		<b>Crownsville State Hospital, Md.</b>		8/9/60					
22a. DATE OF REMOVAL (Specify) <b>8/10/60</b>		22b. DATE THEREOF <b>8/10/60</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Union of Maryland</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. R. Smith</b>		ADDRESS <b>108 W. Wash. St.</b>		24a. REC'D BY REGISTRAR <b>DATE</b>		24b. REGISTRAR'S SIGNATURE <b>AUG 18 '60</b>			

